MILITARY CHAPLAINS' REVIEW

1977

DA PAM 165–112

MILITARY CHAPLAINS' REVIEW

ALCOHOL ABUSE

WINTER, 1977

PREFACE

The *Military Chaplains' Review* is designed as a medium in which those interested in the military chaplaincy can share with chaplains the product of their experience and research. We welcome articles which are directly concerned with supporting and strengthening chaplains professionally. Preference will be given to those articles having lasting value as reference material.

The *Military Chaplains' Review* is published quarterly. The opinions reflected in each article are those of the author and do not necessarily reflect the view of the Chief of Chaplains or the Department of Army.

Articles should be submitted in duplicate, double spaced, to the Editor, Military Chaplains' Review, United States Army Chaplain Board, Fort Wadsworth, Staten Island, New York 10305. Articles should be approximately 8 to 18 pages in length and, when appropriate, should be carefully footnoted.

EDITOR

Chaplain (LTC) John J. Hoogland May 1971—June 1974
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SOME SOBERING THOUGHTS

A "brain teaser," published in a national magazine a few years ago, effectively demonstrated how easily we can be misled while trying to solve a problem. "Be prepared for the answer by the time you finish reading this paragraph, without retracing your steps," said the directions. The paragraph simply recounted the route of a bus. The bus started out empty but took on and let off various numbers of passengers at each stop. Most readers busily added and subtracted those numbers only to be surprised at the end: "Ready with your answer? The question: How many stops did the bus make?"

It's easy to be misled in the course of our ministry by solely concentrating on "relevant" issues while completely ignoring age–old problems that plague us all. Drug abuse, for example, received a great deal of attention some years ago. Many chaplains were admirably involved in various drug abuse programs, providing a spiritual aspect to the selected therapeutic processes. Once the attention on drug abuse subsided, however, many assumed the problem was solved. Then someone asked: "What about alcoholism?"

The National Institute on Alcohol Abuse and Alcoholism tells us that 10 million Americans have severe alcohol problems today. Another 40 million—family members, friends, employers, motorists, etc.—suffer directly from the consequences of that illness.

The potential for alcohol abuse within the Armed Forces is no secret. While the drug scene tragically captured the fascination of some younger service people momentarily, alcohol abuse, especially among career soldiers, has been an omnipresent problem. As Doctor Marc Schuckit begins his article in this issue, "Armed service problems with alcohol have existed since the first soldier took up his weapon." For that matter, as is also stressed in this issue, chaplains and their fellow clergy in the civilian realm are by no means exempt. No rank, no age, no sex, no race, no level of education, no profession is totally immune.

How ever brief or incomplete, this edition is offered as a reminder of the severity of a problem too often ignored. Hopefully, it will also serve as an aid in your ministry to those who suffer from it.

ORRIS E. KELLY
Chaplain (Major General), USA
Chief of Chaplains

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, D.C., *Winter* 1977

MILITARY CHAPLAINS' REVIEW

IN THIS ISSUE

"There is probably no other subject about which people talk with greater enthusiasm, emotion, conviction, authority—and gross lack of knowledge, than alcohol."

——Richard Zylman

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". . . the question of chaplain responsibility to function in the areas of substance abuse is answered in the serious acceptance of the prophetic nature of the ministry."

——H. Harrell Hicks

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"It is a momentous suggestion that a priest should be confronted with the choice of giving up either his drinking or his ministry. . . . Yet this is, in effect, the kind of advice now found in the clergy policies for treatment. . . ."

——Joseph H. Fichter

* * * * * *

"I am a clergyman, and I am a chemically dependent person. . . . I believe my addictive experience gives me some advantage when discussing alcoholism. . . ."

——Duane P. Mehl

* * * * * *

"Many contemporary religious expressions are pale and anemic. . . . When religion loses its spine–tingling quality, alcohol is substituted by many."

——Howard J. Clinebell

SOME FACTS ABOUT ALCOHOL: WHAT IT DOES AND HOW IT DOES IT

Richard Zylman

There are few subjects discussed more universally than the use of beverage alcohol. It is cause for social, emotional, moral, political, medical and economic concern in all segments of society and is the subject of perpetual debate in legislative bodies at all levels of government. Beverage alcohol is spoken of with pleasure, anticipation, relish, delight, satisfaction and gusto, and with disdain, dislike, repugnance and abhorrance, depending on one's point of view. It is a constant subject of discussion in barroom, billet, battlefield, chapel, church, school, business and government. There is probably no other subject about which people talk with greater enthusiasm, emotion, conviction, authority—and gross lack of knowledge, than alcohol.

Everybody talks about what they perceive to be or imagine to be the affects of alcohol, but few people have more than a vague notion as to how alcohol works. In the following paragraphs an attempt is made to bring into perspective some of the more practical aspects of what alcohol does to the body and what the body does to alcohol. It should be noted that this is not intended to be a comprehensive, sophisticated dissertation on the physiology and toxicology of alcohol, but rather, a brief discussion of those aspects of alcohol use that may be of value to those who imbibe.

WHAT DO WE DRINK?

First, it should be recognized that, although there are many different kinds of alcohol, the alcohol we drink, whether it be in beer, wine or distilled spirits, is all the same; it is ethyl alcohol which we will hereafter refer to simply as alcohol.

Before going on we should become aware that ethyl alcohol is the only alcohol consumed by humans because it is the only alcohol the human body can metabolize or breakdown and dispose of. The liver has the capability to chemically break down ethyl alcohol into other substances and ultimately into carbon dioxide and water in which form it leaves the body. Other alcohols have a different chemical makeup that

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the liver cannot handle in the same way. Wood alcohol, for example, can be broken down by the liver but the process takes much longer than for ethyl alcohol. In the meantime the poisons build up in the blood stream and cause severe illness, possible blindness and/or death. Perhaps every barracks, warehouse, motor pool and dispensary should have large signs: WARNING—THE LIVER IS PARTICULAR!

To be sure, there is more alcohol, that is, a greater concentration of alcohol in some beverages than others. In distilled spirits the alcohol content is expressed as "proof" which is twice the alcohol content. Thus, a 100 proof whiskey is 50 percent alcohol and 80 proof beverage is 40 percent alcohol. To put it another way, one ounce of 86 proof whiskey contains .43 ounce of alcohol. Table wines usually consist of 11 to 13 percent alcohol whereas the reinforced or dessert wines contain from 17 to 21 percent. Most American beers contain about four percent alcohol whereas many of the foreign beers contain more. A bit of simple arithmetic reveals that the person who drinks eight 12–ounce cans of beer actually consumes about 3.8 ounces of alcohol, slightly more than the 3.4 ounces in the half pint of whiskey consumed by his drinking buddy; yes, there is more alcohol in a can of beer than in one ounce of whiskey, gin, brandy or rum.

To put it in a different setting, it means that the matron standing with the five ounce glass of sherry in her hand has no cause to regard the young newcomer to the club as a "hard drinker" because she is sipping on a martini. Chances are that the glass of sherry has as much alcohol in it as the martini.

WHAT HAPPENS TO ALCOHOL?

Alcohol is unique. It is not digested but enters the blood stream through the walls of the stomach and small intestine as alcohol. Furthermore, alcohol is a drug and does not have an effect until it reaches the brain where it acts as an anesthetic on the central nervous system.

Absorption from the alimentary canal into the blood begins immediately after one starts drinking. Although the flow of alcohol through the stomach wall is quite rapid at first, it soon slows down and most of the alcohol must pass through the pyloric valve, or pylorus, into the small intestine from which it is rapidly absorbed into the blood stream. This absorption process varies from one individual to another and is more rapid for small amounts of alcohol than for large quantities. It is important to remember that absorption may continue to take place for 45 minutes to an hour–and–a–half after one stops drinking. In other words, one continues to become more intoxicated for some time after he had his last drink.

—*The pylorospasm*:

The pylorus is the culprit at the bottom of a very common

phenomenon. Most people, and especially the young and inexperienced, are protected by the pylorus. If they drink too much too quickly they may experience a pylorospasm which is an involuntary contraction of the pylorus. When this happens the valve between the stomach and the small intestine is closed off so nothing can pass and the drinker becomes nauseous, causing him to abort what might have been a rather intoxicated experience.

—*The blood alcohol concentration*:

The term "blood alcohol concentration" is a term used by scientists who have learned to measure the effects of alcohol in relation to its concentration in the blood.

The human body can burn off or dispose of about one–third of an ounce of alcohol per hour. This rate is constant and cannot be altered by strenuous exercise, cold showers or black coffee. About 90 percent of the alcohol is disposed of by the liver and the remaining 10 percent via the urine, breath and perspiration. Theoretically, one could drink two cans of American beer every three hours indefinitely (or until his liver wears out) without becoming intoxicated. That is because he is consuming alcohol at about the same rate that his body is disposing of it. As soon as he begins to drink more rapidly the concentration of alcohol in his blood—and in his brain—will begin to rise. The more rapidly he drinks, the more rapidly and higher the blood alcohol concentration rises and the greater will be the effect on the brain.

—*Body weight*:

Mention was made above that the effect of alcohol is measured in relation to its concentration in the blood. That has a practical application. A given amount of alcohol in a small body will have a considerably greater effect than the same amount in a large body. For example, a half pint of vodka consumed in one half hour by a 140 pound person would yield a concentration of 200 milligrams of alcohol per 100 milliliters of blood compared with a concentration of 100 milligrams per 100 milliliters of blood in the 220 pound man. Therefore, all other things being equal, the small man will become much more intoxicated than the large man drinking the same amount of beverage alcohol.

—*Time*:

The amount of time used to drink is also important. As stated above, the 140 pound person ingesting 8 ounces of vodka in one hour would have a concentration of 200 milligrams of alcohol per 100 milliliters of blood an hour after he stopped drinking. Because the body burns off or metabolizes alcohol at the constant rate of one–third of an ounce of alcohol per hour which is equivalent to a concentration of 15 milligrams per 100 milliliters, he is actually burning alcohol while he is drinking it. Therefore, the longer it takes to drink the less will be the effect. In the case of the 140 pound person above, he would be quite intoxicated if he

had consumed that half pint of vodka in one hour. However, if he were to sip at it over a period of four or five hours he would only be mildly high.

ALCOHOL, A STIMULANT OR DEPRESSANT?

Contrary to widely held beliefs, alcohol is not a stimulant, but a depressant. The misconception arises, apparently, because the early effects of alcohol are felt as a relaxant; it relieves tension, makes one more "outgoing," enables one to converse more easily and "stimulates" the appetite. It also tends to raise the noise level at parties, and makes loneliness and boredom more tolerable. Actually, alcohol depresses that portion of the brain first that controls those things we learned most recently including our tendency to worry, to be inhibited in conversation, to limit our food intake, to restrict ourselves to socially acceptable conversation—and to observe the distinction of rank. One of the first things alcohol does for us then, is to make all those things come easier that would otherwise be cause for concern. This is what makes alcohol such an essential element in so many social gatherings; by depressing that part of the brain that controls inhibition the less inhibited behavior appears to be stimulated. The desired effect can be achieved by most people on one or two drinks, *i.e.*, with a very low concentration of alcohol.

—*The nature of impairment*:

Unfortunately, many of us do not limit ourselves to one or two drinks nor are these "desirable" effects the only effects of low concentrations. Even at these levels alcohol begins to have an effect on various faculties. For example, after two drinks (or two cans of beer) our light threshold is altered. That is, alcohol has a dimming effect on our vision so that we need more light to see a dimly lit object. This could be critical while on patrol at dusk or performing other nocturnal duties. Similarly, the pupils normally control the amount of light entering the eyes by expanding in darkness and contracting in light. This important reflex is disrupted by alcohol; the result is that many persons are more easily blinded by sudden changes in light conditions after they have had a few drinks.

It should also be noted that the eyes transmit individual images to the brain where they are coordinated so we see only one image. One of the early effects of alcohol is to anesthetize the many nerves from the eyes to the brain disrupting the transmission of messages which results in blurred or double vision.

Alcohol also causes a delay in perceiving danger because the information processing mechanism in the brain is anesthetized and, once a danger is recognized, the resulting action may be too late, too early, awkward or simply wrong. Many of these impairments can and do occur

even though the drinker is not visibly intoxicated.

This brings us to another misconception. It is generally believed that impairment goes up in direct proportion to the amount drunk; *i.e.*, that two drinks will have twice the effect as one drink, that three drinks will have three times the effect, etc. Nothing could be further from the truth. Research has shown, for example, that if a 160 pound man drank four cans of beer in three hours his chance of causing a crash would be about twice what it was when he had nothing to drink, with five cans of beer the likelihood would be four times greater, with six beers, six or seven times as great and that with eight cans of beer the likelihood of causing a crash would be about 25 times as great as if he had had nothing to drink.

This also ties in with the earlier statement that the concentration of alcohol in the blood can continue to rise for 45 minutes to one–and–a–half hours after the drinking stopped. Simply illustrated, it means that if one takes his sixth and seventh cans of beer shortly before leaving a party his chance of causing an auto crash will rise from about six times greater than if he had nothing to drink (at the time he left the party) to about 25 times greater less than an hour later. That is because the alcohol from his last few drinks is still entering the blood and the concentration of alcohol continues to rise. *The impairing effect of those last two drinks is several times greater than the effect of the first two drinks. For practical purposes this should rule out that "one for the road."*

—Don't play Russian roulette:

While discussing the nature of impairment mention should also be made of another phenomenon that seems to occur too often in the military. Although the game of Russian roulette is generally frowned upon and most military personnel would move to discourage such a contest, very few would recognize the danger in a drinking contest. As a matter of fact, the drinking contest may be equally as deadly as the game with the loaded chamber. This usually happens after the participants have already had a few drinks to relieve them of their inhibitions and judgement while at the same time bolstering the male ego. In one way or another they are challenged to drink a large amount of alcohol in a short time. Fortunately, the pylorospasm described earlier may intervene and cause the contest to abort in a usually ignominious fashion. On the other hand, there are too many cases in which the contestant succeeds in the ingestion of a large amount of alcohol and he rapidly proceeds through the stages of being high, drunk, stuperously drunk and "passed out." This is where the danger lies. There may be sufficient alcohol still in the stomach which, if it continues to absorb into the blood, could cause the concentration to rise to perilous limits. Whereas those around him, who quite likely had also been drinking, regard his passing

out as cause for fun–making the contestant, now the victim, may be lying at death's door. While he may appear to have gone to sleep it is equally possible that he is passing into the deep coma that occurs as the concentration of alcohol in the blood, and subsequently in the brain, continues to rise. It will continue to rise as long as there is alcohol left in the stomach, while at the same time having an increasingly greater anesthetic affect on the brain until respiratory functions, paralyzed by alcohol, cease to function. Death ensues.

—*Just beer*:

Beer is widely regarded as the beverage of moderation. This misconception is not without support. Beer is freely advertised on radio and TV whereas distilled spirits are not, in many jurisdictions beer is sold in grocery stores much like coke whereas distilled spirits are not, distilled spirits are more heavily taxed than beer and beer dispensing machines are ensconced in military quarters. So there are many reasons to believe (incorrectly) that beer is less harmful than distilled spirits.

These beliefs are reinforced by one's own experience. It seems to be widely believed that when one gets down to serious beer drinking and then begins to urinate with about the same regularity as he is consuming beer, the beer is "going right through" and having little or no effect. Actually, what is passing through is the excess water and just a very small proportion of the alcohol. As the beer passes through the system the alcohol is absorbed into the blood stream through the wall of the stomach and small intestine as described earlier. Although it may take longer to become intoxicated on beer, it can be done without great effort. As stated earlier, *there is more alcohol in a can of beer than in an ounce of whiskey, brandy, gin or rum.*

There is plenty of reason to believe that the excessive use of beer is harmful. The majority of persons arrested for driving while under the influence of alcohol name beer as their beverage of choice and the majority of persons involved in auto crashes after drinking are beer drinkers. Many of these have been diagnosed as "alcoholics."

However, it should not be concluded that because a majority of those arrested or involved in alcohol–related collisions and fatal crashes preferred beer that beer is more dangerous than distilled spirits. It is more likely that youth and drivers from the lower social status who would be involved in a disproportionate number of accidents with or without alcohol are also more likely to be beer drinkers. In other words, it is a socio–cultural phenomenon as much as a toxicological effect.

It goes without saying that limiting one's consumption of alcohol to beer is no guarantee against developing problems related to alcohol.

MILITARY PERSONNEL: A HIGH RISK GROUP

Finally, if it appears that problems related to the use of alcohol are more heavily concentrated among military personnel than among the civilian population it is probably true:

1. Although less than half of the civilian population is male, those identified as problem drinkers are preponderantly male; on that account alone, because military personnel are largely male, a larger portion of the military population than of the civilian population could be expected to be problem drinkers.

2. To the extent that alcohol problems are most prevalent among persons between 20 and 45 years old a higher frequency of problem drinkers can be found among the military personnel.

3. Although problems related to alcohol are found in all strata of society, they are more numerous among those of lower social status. To the extent that the lower social status is over–represented among military personnel, alcohol problems will likewise be more numerous among the military than among the civilian population.*

4. To the extent that a lack of family structure and mode of living is conducive to increasing alcohol related problems, such problems can be expected to be more prevalent in the military than in the civilian population.

5. To the extent that boredom, loneliness and frustration are conducive to excessive drinking, such drinking can be expected to occur more often in a military population.

6. To the extent that peer group support for drinking tends to increase the use of alcohol, the relative homogeneity of military society is conducive to increased drinking.

It is clear that the military population is highly exposed and vulnerable to alcohol related problems. It is equally clear that the kind of practical information presented here should be widely disseminated as a matter of survivability until methods are found to prevent or correct the abuses of alcohol.

*It should be noted that we are speaking here of problems related to alcohol, not alcoholism. Alcoholism is generally not a respecter of social status. But members of the lower group suffer more from any social problem because they lack the personal education, training, and resources used by the higher group to cope with such problems.

ALCOHOL PROBLEMS IN THE UNITED STATES ARMED FORCES

Marc A. Schuckit, M.D.

Armed service problems with alcohol have existed since the first soldier took up his weapon. I deal here, therefore, not with a new topic, but with a short review of problems which have existed for a long time but which have not been adequately studied until recent years. Most of the data I will relate comes from the United States Navy, but the findings probably generalize to other branches of the service. Due to space limitations, I have referenced mostly my own works, each of which has a bibliography which I hope you will use. My discussion will cover epidemiology, subtypes of alcoholism and treatment and prevention issues.

EPIDEMIOLOGY

It is not possible to review all articles on the epidemiology of alcohol problems in the United States armed services, and the reader is encouraged to seek other references. The discussion here is divided into data on drinking practices and the studies of hospitalized alcoholics.

—*Studies of Drinking Problems*

The first major report of interest was published in January of 1973, by Dr. Donald Cahalan and his associates, describing patterns of alcohol use and abuse in the United States Army.[1] A random sample of 383 officers, 495 petty officers and 5,579 enlisted men completed a questionnaire in 1972 on drinking practices and problems which occurred over the prior three years. The results were then compared with civilian findings on both quantity–frequency and problem drinking measures. Heavy drinking was defined as consuming five or more drinks at a time on four or more days per week, while problem drinking was diagnosed if at least one of the following alcohol–related difficulties had occurred: personal interrelationship problems; police difficulties, including driving; health problems; job problems; or any service-related disciplinary difficulties involving alcohol.

[1] D. Cahalan, I.H. Cisin, G.L. Gardner, *et al.*, "A Study to Measure the Extent and Patterns of Alcohol Use and Abuse in the U.S. Army," Report of Navy Medical Neuropsychiatric Research Unit, San Diego, CA, 1973.

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The study revealed high rates of heavy and problem drinking for all ranks, with more prevalent problems for younger men and personnel at overseas stations. Problems were especially likely to occur if individuals were separated from their families. Men without college educations and soldiers whose fathers were heavy drinkers were also more likely to report alcohol problems themselves.

The results gathered by Cahalan, *et al.*, were compared with his survey of drinking practices of male civilians, age 21 to 59, carried out in 1966 through 1969, as shown in Table I. It is apparent that heavy drinking and the occurrence of problems associated with drinking are common for American men. Compared to civilians, more officers are drinkers and heavy or binge drinkers, but slightly less are problem drinkers. More enlisted men drink heavily and have problems when compared to officers or comparable civilians.

TABLE I

PERCENTAGE DISTRIBUTION OF DRINKING BEHAVIOR AND PROBLEMS FOR ARMY AND CIVILIAN MEN AGE 21–59*

	Officers		Enlisted Men	
	Army	Civilian	Army	Civilian
N	4297	978	4477	978
Non Drinkers	4%	11%	2%	9%
Drinkers—No Problems ..	59%	53%	30%	50%
Heavy or Binge Drinkers—No Problems ..	20%	16%	32%	17%
Problem Drinkers	17%	20%	35%	25%

*Data extracted from tables 1 and 2 of D. Cahalan, I.H. Cisin, G.L. Gardner, *et al.*, "A Study to Measure the Extent and Patterns of Alcohol Use and Abuse in the U.S. Army," Report of Naval Medical Neuropsychiatric Research Unit, San Diego, CA, 1973; D. Cahalan and I.H. Cisin, "American Drinking Practices: Summary of Findings from a National Probability Sample I; Extent of Drinking by Population Subgroups," *Quart J Stud Alc*, 29:130–152, 1968.

TABLE II

PERCENTAGE DISTRIBUTION OF DRINKING BEHAVIOR AND PROBLEMS FOR NAVY MEN IN 1972*

	Officers	Enlisted
N	706	892
Non Drinkers	3%	3%
Drinkers—No Problems ..	59%	36%
Heavy or Binge Drinkers—No Problems— .	16%	22%
Problem Drinkers	23%	39%

* Data extracted from table 10 of D. Cahalan and I.H. Cisin, "Analysis of Drinking Behavior and Attitudes by Race," Report of Bureau of Social Science Research, Inc., 1975.

A second report was published in February of 1973 by Cahalan and Cisin at the Bureau of Social Science Research.[2] The main thrust of their work was to compare mailed and field–administered questionnaires of drinking practices in the United States Navy—but the results shed light on the actual prevalence of problems. Questionnaires were completed by 806 officers and 1,179 enlisted men (with an overall completion rate of over 80%) in four selected localities. The results of the two methods were quite similar and will be pooled for the discussion given below.

Table II was extracted from the original Table X by Cahalan, *et al.*, by combining mailed and administered questionnaire results. Problem drinking was defined slightly differently by the original authors than is outlined in Table II—in Table II, this concept refers to men who reported *numerous* unfavorable consequences of drinking, rather than any one problem. The results corroborated the findings in the Army of a higher rate of problem drinking for enlisted men than officers, and for lower ranking men within respective officer/enlisted groups. These figures were in the same range for the army officers and enlisted men.

Thus, heavy drinking and the occurrence of alcohol–related life problems were common in both civilian and military settings. The overall problem drinking range for the military (officers and enlisted) is 26% in Table I, and 32% in Table II, while comparable figures for civilians in Table II were 22%. The military statistics paralleled civilian findings with higher rates of problem drinking in younger men with lower educational background and heavy drinking fathers.

—*Studies of Diagnosed Alcoholism*

It must be emphasized that the two surveys discussed above did not deal with alcoholism, but with drinking problems. Complementary to these findings, the staff of the Naval Health Research Center (formerly the Naval Medical Neuropsychiatric Research Unit) has carried out a series of investigations of men hospitalized with a diagnosis of alcoholism.

In order to fully understand the reported data, the biases involved in the collection of information must be kept in mind. We are reporting a hospitalized population rather than a clinic or population survey—there are differences in degree of illness, socioeconomic class, etc.[3] We are also dealing with a first hospitalization rate which counts each individual admitted for the first time during the study period, a manner of reporting we chose because, with a large sample, it insures

[2] D. Cahalan and I.H. Cisin, "Analysis of Drinking Behavior and Attitudes by Race," Report of Bureau of Social Science Research, Inc., 1975.

[3] M.A. Schuckit, "Family History and Half–Sibling Research in Alcoholism," *Ann NY Acad Sci*, 197:121–125, 1972.

that each patient is counted only once. Also, because we are studying a large group of men (an extensive approach),[4] our methodology allows gathering of small amounts of information on each man, but does not allow for in–depth (an intensive method) study of any individual.

The first study deals with hospitalization rates for alcoholism in the Navy and Marine Corps during the fiscal years, 1966 through 1969.[5] The overall rates of hospitalization for alcoholism were 74 and 44 per 100,000 for the Navy and Marine Corps, respectively. These rates were high, compared to male civilian populations in the same age group, which ranged from 60 per 100,000 for Ireland to 4 per 100,000 for England and Wales.[6] The hospitalization rate increased dramatically with age after age 25 and continued to rise for both Navy and Marine Corps until after age 40, going from approximately 25 per 100,000 less than age 25 to over 400 per 100,000 at age 40.

First hospitalization rates are not comparable to general alcoholic prevalence. For example, while official first hospitalization rates for alcoholism in England and Wales was approximately 4 per 100,000, the rate of alcoholism prevalence was estimated to be about 1,100 per 100,000—a three hundredfold difference. This, of course, is because most alcoholics never come to hospitalization, and of those who are hospitalized, most do not receive an official notation of alcoholism in their charts. While the actual prevalence of alcoholism could not be determined directly for the study reported, reasonable estimates generated from the first hospitalization rate would be in the range of 2% to 5% of all Naval personnel.

In summary, the rate of men reporting some alcohol–related problems in the service is in the range of 25% to 33%. The actual rate of alcoholism (more severe and pervasive difficulties) is probably in excess of 5%. These figures are probably slightly higher in the service than in the general male population and, of course, represent huge losses in manpower to the military.

POSSIBLE SUBTYPES OF ALCOHOLISM IN THE NAVAL SERVICES

Alcoholics are not homogeneous. It is important to try to determine whether there are subtypes of alcoholism in the armed services, as differences may reflect various causes and might determine treatments or predict different prognoses. Among the possible subtypes that could be discussed here are: officers *vs.* enlisted men; men *vs.* women; older men *vs.* younger men; alcoholics in different job types; different al-

[4] B. MacMahan and T.F. Pugh, *Epidemiology: Principles and Methods* (Boston: Little, Brown & Co., 1970).

[5] E.K.E. Gunderson and M.A. Schuckit, "Hospitalization Rates for Alcoholism in the Navy and Marine Corps," *Dis Nerv Syst*, 36: 681–684, 1975.

[6] D. Walsh, "Alcoholism in the Republic of Ireland," *Brit J Psychiat*, 115:1021–1025, 1969.

coholic clinical pictures; and finally, those men with *primary alcoholism* (alcohol problems in the absence of other pre–existing psychiatric disorders) *vs.* those men whose alcohol problems appear to be *secondary* (at least in onset and time course) to another major psychiatric disorder. We don't have enough space to deal with all of these, but discussion of a few possible subdivisions is in order.

It has been well documented that there are differences in clinical picture and course for alcoholism for individuals of different economic and educational levels.[7] Thus it is not surprising that there are differences in alcoholic pictures between naval service officers and enlisted men. Compared to alcoholic enlisted men, alcoholic officers are older (40 *vs.* 33 years), have more years of service (19 *vs.* 12 years), and more stable marriages (85% married and 1% divorced *vs.* 52% married and 6% divorced).[8] These differences may result from a later onset of alcoholism in officers or, more probably, delayed recognition of severe alcohol abuse in the officer ranks. The overall rate of hospitalization for alcoholism in officers (35 per 100,000) compares favorably with the rate for enlisted personnel (approximately 60 per 100,000). However, this reflects differences in socio–economic strata and education, and it must also be kept in mind that officers undergo more rigorous screening before entering officer ranks and would be more likely to have the financial resources to receive treatment outside the service if they were afraid that the notation of alcoholism in their records would jeopardize their future career. It is also possible (and somewhat probable, although there is no data for this) that physicians might be even more reluctant to label an officer alcoholic than is true when dealing with an enlisted man.

Much more data is available on alcohol problems and alcoholism in men than is true for women.[9] This difference is even more acute in the military service where the ratio of men to women and the very rigorous screening of women, as well as administrative procedures leading to early discharge of women showing any kind of emotional difficulty [10] makes the gathering of adequate data on the incidence of alcoholism in women in the service quite difficult. Nonetheless, we carried out an investigation of women hospitalized with a diagnosis of alcoholism in the Naval service between July, 1965, and December of 1970.[11] There were 32 Navy enlisted, 9 Marine Corps enlisted, and 8 Navy officer women

[7] D. Cahalan and I.H. Cisin, "American Drinking Practices: Summary of Findings From a National Probability Sample I; Extent of Drinking by Population Subgroups," *Quart J Stud Alc*, 29:130–152, 1968; M.A. Schuckit and E.R. Morrissey, "Alcoholism in Women: Some Clinical and Social Perspectives," in M. Greenblatt and M.A. Schuckit, eds, *Alcohol Problems in Women and Children* (New York: Grune & Stratton, in press).

[8] M.A. Schuckit and E.K.E. Gunderson, "Alcoholism Among Navy and Marine Corps Officers," *Military Med*, 139:809–811, 1974.

[9] Schuckit and Morrissey in *Alcohol Problems in Women and Children*.

[10] M.A. Schuckit and E.K.E. Gunderson, "Psychiatric Incidence Rates for Navy Women: Implications for an All Volunteer Force," *Military Med*, 139:534–536, 1974.

[11] M.A. Schuckit and E.K.E. Gunderson, "Alcoholism in Navy and Marine Corps Women: A First Look," *Military Med*, 140:268–271, 1975.

who received an alcoholic diagnosis based on the standard nomenclature being used at that time.

At first glance, the rate of hospitalization for alcoholism for Navy and Marine Corps enlisted women (90 per 100,000) and for Navy officers (50 per 100,000) was in the same general range as that seen for Navy enlisted men and male officers. However, a large proportion (32 of 49) of the supposed alcoholic women were young individuals who did not fulfill independent criteria for alcoholism once their charts had been reviewed. It appeared as if most had disciplinary difficulties and others appeared to be situational drinkers whose mild rule infractions resulted in short hospitalizations to facilitate sobering up. Most service or civilian men under similar circumstances, such as returning to their quarters or homes intoxicated, would not have been hospitalized. There was also a subgroup (17 of 49) of the women who were older (a mean of 37 years), had been in the service and worked an average of 15 years, and whose alcohol problems were quite serious. For these women, alcohol and health difficulties were similar to those reported for both civilian and military alcoholic men.

Among officers, there is also a job breakdown distinction for rates of alcoholism, but the differences are nowhere near as dramatic as was true for enlisted men.[12] One factor which is interesting for this presentation is that the Chaplain Corps had a slight but significantly elevated rate of alcoholism when compared to other categories.[13]

Another way to subdivide alcoholics is based on the clinical picture at the time of hospitalization. The diagnostic nomenclature which must be recorded officially for each case encourages the physician to note a subdivision of alcoholism type. Prior to 1970, the military service used the subdivisions of "acute," "chronic," "psychosis," and "unspecified," which gave way after January 1, 1970, to the new ICDA–8 diagnostic breakdown of "habitual," "addiction," "episodic," "psychosis," and "other." Because of our clinical impression that the criteria for subdividing alcoholics in diagnostic manuals were unclear, we investigated the relative usefulness of this subtypic scheme.[14] As viewed from the military service, there was no evidence that the alcoholic subtype diagnoses were selecting relevant subtypes—a criticism especially true for the scheme introduced after 1970. With the advent of the new system, the percentage of men diagnosed as "other" or "unspecified" jumped from 6% to 40%, indicating that most clinicians found the new subtypic divisions to be relatively useless. This, coupled with

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[12] M.A. Schuckit and E.K.E. Gunderson, "Association Between Alcoholism and Job Type in the U.S. Navy," *Quart J Stud Alc*, 35:577–585, 1974.

[13] Schuckit and Gunderson, "Alcoholism Among Navy and Marine Corps Officers."

[14] M.A. Schuckit and E.K.E. Gunderson, "The Use of Alcohol Subtype Diagnoses in the U.S. Navy," *Dis Nerv Syst*, 35:231–236, 1974.

the relative lack of prognostic meaning for the various subtypes on follow–up, indicates that the ICDA–8 diagnostic scheme adds little to the original diagnosis of alcoholism.

Another way of attempting to subdivide alcoholics is based on the presence or absence of prior psychiatric disorders. The reasoning behind this approach is that an individual who demonstrates the probability of two psychiatric problems is unlikely to follow the general course of either one.[15] Therefore, if one wishes to establish the cause, course and best treatment for a group of alcoholics, it is best to have as homogeneous a population as possible and unwise to attempt to make generalizations from men with mixed diagnoses.

In summary, while valid generalizations about alcoholics can be found, possible subtypes of this disorder should be recognized. In thinking about military alcoholics, such factors as officer *vs.* enlisted status, sex, job type, clinical pictures and primary *vs.* secondary illness must be considered.

TREATMENT AND PREVENTION ISSUES

I have outlined for you studies which have dealt with the probable rate of alcohol problems in the armed services, the rates of hospitalization for alcoholism in the service, and the possible clinical subtypes. The characteristics of alcoholics have been examined from different perspectives and the results discussed. There is also data which reflects on the activities of the service in attempting to fight this major health problem.

In approaching any new or longstanding illness, there are a number of steps which can be taken. It is my bias that all interference has potential for causing harm—no matter how innocuous the procedure may be. From this perspective, I would urge that a treatment or prevention program instituted to respond to a crisis begin with careful documentation of its actions. One step is to determine the state of the problem, how severe and widespread it is. Second, all goals and procedures need to be clearly defined—it can't be assumed that everyone is talking about the same thing. Third, it should be recognized that results count, and that some day we will be asked to stand or fall on our records. Therefore, it is important that treatment programs plan for evaluation from day one by establishing good record keeping and adequate procedures for follow–up.

The armed services have responded to a variety of pressures in establishing alcohol treatment programs. Their interest, while genuine, appears to be fading slightly, but those actively involved in alcohol treatment are doing their best to remind the military that great losses in

[15] M.A. Schuckit, "Alcoholism and Sociopathy—Diagnostic Confusion," *Quart J Stud Alc*, 34:157–164, 1973.

money and manpower occur through alcoholism. In addition, it is important to point out that deaths through suicide and through a variety of medical problems can be expected in alcoholics unless treatment begins.[16] The Naval Health Research Center, along with the Division of Alcoholism of the Bureau of Naval Personnel, is attempting to collect good descriptive and prognostic data on all alcoholics who enter treatment for the Navy anywhere in the world. Similar programs are being reported in the other armed services. Adequate evaluation requires that individuals under treatment be compared to those who have received no treatment and that an adequate length of time be allowed to elapse for good follow–up. Thus, it is not possible to definitively discuss the level of efficacy of our present efforts, but we can take solace in the fact that this will be possible at a future date.

In the meantime, there are a series of studies which have been reported which have looked at intervention techniques utilized before the present Alcoholism Center, Unit, and Drydock network of facilities were established. In the 1950's, a series of anecdotal and descriptive studies of small–scale alcoholism treatment programs was reported.[17] Most showed success rates in excess of 50%, but used short–term follow–up (usually less than one year), with loose designs often lacking in precise definition of alcoholism or therapeutic goals and utilized imprecise measurement instruments. Not unlike today, the therapies included antabuse, group or individual therapy, and Alcoholics Anonymous.

Program descriptions written in the 1960's and 1970's were similar to the earlier reports in treatment methods, rates of success, and problems with study design.[18] Most programs were found to be selective, accepting for treatment only the best risk patients and then only evaluating outcomes for those men who remained in therapy for a set period of time. Two studies were done in the Navy by the Naval Medical Neuropsychiatric Research Unit, and these are discussed in slightly more detail.

In one study undertaken by the Unit, biographical data was collected on 4,950 Navy male enlisted psychiatric inpatients at 31 Naval Hospitals during the period of 1967 through 1968.[19] The outcome for the 142 men with alcoholic discharge diagnoses was compared to the remaining psychiatric patients. The alcoholics were more frequently returned

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[16] M.A. Schuckit and E.K.E. Gunderson, "Suicide in the Naval Service," *Amer J Psychiat*, 131:1328–1331, 1974; M.A. Schuckit and E.K.E. Gunderson, "Deaths Among Young Alcoholics in the U.S. Naval Service," *Quart J Stud Alc*, 35:856–862, 1974.

[17] M.A. Schuckit and E.K.E. Gunderson, "Evaluation of Naval Alcohol Rehabilitation Programs: Problems and Suggestions," presented at National Conference on Evaluation in Alcohol, Drug Abuse, and Mental Health Programs, Washington, DC. Apr 1–4, 1974.

[18] *Ibid.*

[19] *Ibid.*

to duty from the hospital (74% *vs.* 28%), which may have reflected the older age of the alcoholics and the tendency of the military to return to duty more mature men with longer service histories. Once back on duty, 64% of the alcoholics successfully completed their enlistments and were recommended for reenlistment by their commanding officers. This high rate of return to duty and high rate of success once back at work resulted from hospital–based inpatient programs, with one exception, the special alcohol rehabilitation programs had not yet been established.

The advantage of a special alcohol rehabilitation facility was evaluated in 1969 in another study.[20] A group of 164 men who had been returned to duty after going through the Alcohol Rehabilitation Center (ARC) at Long Beach, California, were matched on alcoholic diagnosis, date of return to duty, rank, and length of military service with a group of alcoholic men returned to duty after routine inpatient psychiatric treatment. There were 87 matched pairs; in 39 pairs, the Alcohol Rehabilitation Center and hospital treatment patients did equally well. Of the remaining 48 pairs, in 25 the Alcohol Rehabilitation Center men had better service performance, while in 23 the hospital–based treatment center patients did better. The overall improvement rate by these criteria was 42% with similar results for ARC and hospital treatment programs.

As the naval service alcohol treatment programs have expanded through the establishment of nonhospital based treatment facilities, it can be expected that less severe alcoholic men (and some who are probably not alcoholic at all) will be entering treatment. When this occurs, it can be expected that the rate of response to treatment will improve.[21] The results should parallel those reported in most private industries, where 70% of men who receive alcoholic treatment report some high level of improvement. This high rate of response to therapy reflects the fact that men with relatively stable backgrounds and—some might say—less severe alcoholism, are entering care. Most men in an industrial as well as military setting have a job intact, are valued enough by their employer, here the military, to be referred for treatment, have an intact family, and have demonstrated some general strengths in the past. Also, due to screening procedures for jobs, most sociopaths (men with the worst prognoses of all) will have been screened out.

In summary then, it appears as if most military alcohol treatment programs follow a model similar to that presented for civilian treatment centers. They, in general, are working with good prognosis alcoholics and appear to be utilizing a good common sense approach and following industrial alcohol program lessons in dealing with alcohol problems. It is

[20] *Ibid.*

[21] M.A. Schuckit and D. Cahalan, "Evaluation of Alcohol Treatment Programs," in W.J. Filstead, J.J. Rossi, and M. Keller, eds, *Alcohol, New Thinking, and New Directions* (in press).

not possible as yet to document the effectiveness of these programs definitively, but the mechanism for these evaluations has been established and data is presently being gathered.

Prevention of alcoholism, on the other hand, is much more difficult to evaluate. Most prevention programs utilize education and early identification of cases. Adequate evaluation of the effectiveness of these programs would depend upon random assignment of individuals to prevention and non–prevention programs and prospective following up of people over the next five to ten years. These are very costly studies and I know of none being carried out within the military service.

Nonetheless, the military is using a realistic approach to the problem. The changes in administrative guidelines for handling alcoholics and attempts at assuring alcoholics who enter treatment that their careers will not be retarded have encouraged early identification as one prevention mechanism. A number of the armed services are also considering elimination of inexpensive liquor, frequent happy hours, and the near requirement that people attend cocktail parties where liquor flows freely. These common sense approaches to prevention should continue, and it is hoped that the military services will institute more formal prevention programs, a strong component of which would be prospective evaluation studies.

SUMMARY AND CONCLUSION

This paper has documented the fact that alcohol problems are not new to the military, and that it has only been in the last five to ten years that military services in this country have turned resources to the treatment and prevention of these problems. Because the average individual in the military service is a male between the age of 18 and 25, studies have demonstrated that alcohol–related life difficulties occur frequently in the service. Rates of problems, while not dramatically higher than the general population once one controls for socio–economic strata, are at slightly higher rates in the service and represent major losses in money and manpower to the military.

The rate of officially diagnosed alcoholism in the service is also slightly higher than that seen in the civilian population. The statistics reported here are changing over the years as administrative procedures are being revised and more treatment centers are being made available. It appears as if there are relevant subtypes of alcoholics based on prior psychiatric problems and sex as well as military pay grade standings. Finally, military service treatment programs are as effective as industrial setting treatment programs anywhere in the world.

This brief discussion of a vast topic has been presented in an attempt to whet the appetite of the reader. To gain an adequate understanding of the scope and proper handling of alcohol problems in the

military, you are encouraged to read the references presented with this paper, to expand your own clinical experience with alcoholism, and to encourage and participate in research in this important problem in the military service.

FIVE STORIES, A FEW QUESTIONS, AND SOME CONCLUSIONS

Chaplain (CPT) William C. Noble

Each of the following stories has to do with the Army system and alcoholism or compulsive behavior. In the sense that no one is to be blamed, the people of the stories are innocent. But in each of these stories there is no effective intervention—no one accepts the responsibility.

These events occur in the future. But they are written in the hope that our "knowledge" of the future will change our reaction to the present.

The stories are, of course, fiction.

I

It's the morning of February 3, 1977. One hour from now, Mrs. Louise Jackson is supposed to drive down the hill to the split–level home of her neighbor and best friend, Charlotte Miller. Louise is to deliver the coffee cake for the monthly meeting of "Great Books." But Mrs. Jackson's 16–year–old son, Mike, makes a telephone call.

"Hello, Mrs. Miller? This is Mike. I'm sorry, but Mother won't be able to make it this morning. And I hope you can get along without the cake."

Two hours before that call, Lieutenant Colonel Matthew Jackson, Louise's husband, left for his office on post as she awoke with a splitting headache and no memory of the "Hail and Farewell" party the night before. She stumbled to the kitchen, closed the back door, and, unable to hold a coffee cup, finished a fifth of bourbon to steady her nerves.

By the time her son made the telephone call, Louise Jackson had passed out in the shower. Mike had covered for her. But because he's already late for school, he will leave her there.

. . . .

For twelve hours that day, who cares about Louise Jackson? Who will care what she feels? Who will care what she says? Who will care what she does?

Chaplain Noble is an Episcopal priest and Religious Consultant to the Human Relations Division, Fort Polk, LA. Before entering the Army, he served as a counselor for two years in the Community Residence Center for Alcoholism and Drug Abuse, Statesboro, GA.

II

It's the afternoon of February 3, 1977. In a faded trailer parked by one of the dusty roads of Ellis' Trailer Park in the shade of three Louisiana long–leaf pines, two–year–old Jenny Lee Spivey, lonely, curious, and hungry again, wanders from the bedroom to the hallway to the bathroom.

Jenny's mother, taking her first and regular afternoon break from washing and worry since she waved goodbye to her husband, Private Johnny Spivey, at five that morning, throws herself onto the couch in front of the "tube." Without thinking, she adjusts the blinds to get the glare off the picture, and quickly, for a moment before her program comes on, pulls her long, brown hair away from her face and ears.

Mrs. Spivey doesn't hear her daughter's footsteps, nor does she hear the familiar creak of the medicine–cabinet door—only the blaring, more familiar theme of "As The World Turns."

. . . .

For thirty minutes that day, who will care about Jenny Lee Spivey? Who will care where she is? Who will care what she does?

III

It's late in the afternoon of February 3, 1977. Private George Gilmore leaves the company area in his red '68 pick–up. He waits nervously in the inevitable line at the front gate, then drives the 80 miles to the flat Texas town where he grew up. He stops—as he has each day—for gas and a six–pack at Hamon's Corner. When he gets home, his mother is cooking supper for the four younger children and herself. She hardly notices the persistent grinding of the lawnmower as he cuts the grass or the empty rattle of the screen door as he leaves.

Later that night, after three more six–packs and a lot of "riding around," George speeds through town as fast as he can. When the cop who's parked by the drug store doesn't chase him, he squeals his tires three times around the Court House Square and pulls up behind the patrol car. His lights shine on the bald head of the sleeping policeman.

Four hours later, in the flat, wispy, pre–dawn fog, Private Gilmore begins his drive back to the post.

. . . .

For twelve hours that day, who will care about Private George Gilmore? Who will care where he is? Who will care what he says? Who will care what he does?

IV

The sun seems to set early in winter, but February 3, 1977, is a long day for Sergeant First Class Stan Whittlesea. His wife, Mary, had

called to him as he ran for the car, "Don't worry, Honey, you don't drink that much." His buddies in the shop had said, "Don't sweat it, Sarg." Still, SFC Stan Whittlesea spends the morning of February 3, 1977, in dread. Thanks to a fifth of rum under the front seat of his car, Stan made it through the morning and to the commanding officer's office for his 2:00 p.m. appointment with the "Old Man."

"Sergeant Whittlesea, you are a good supply sergeant. But you are an alcoholic. During the last month I have had to personally rewrite four of your reports. I've had to speak to three of your creditors, and I am tired of hearing how you can't make it to morning formations. Listen, I know there are people who drink on the job in the Army, but you're not going to do it as long as you're in my unit. Frankly, I think that's what you have been doing and that's why you're often late. You've got to get yourself together. Do you have anything to say?"

"Sir, it's cold out there in the shop. Sure, I have a couple of nips now and then. But so do a lot of other people I know."

"Sarg, I want you to get yourself together. Do you understand?"

"Sure, Sir. I'll straighten up. The old lady has been after me about cutting down."

By 2:30 p.m. on February 3, 1977, the dread that Stan Whittlesea had known in the morning has quietly turned to anger—anger toward authority, anger toward his wife, and anger toward himself. But he will not think of that. He will only think of the welcoming plastic opulence of the NCO Club and of telling his friends that the CO has been in his case again. He will think of drinking, and of forgetting. At midnight, when the club closes, SFC Stan Whittlesea will drive home alone—and drunk.

. . . .

For six years who has cared about Stan Whittlesea's drinking? Who has cared about his job performance? Who has cared about him?

V

It's midnight, February 3, 1977. Jerry Kuhlow has been thrown into the "tank" at the Dooly County Jail by a deputy who has known Jerry since the day he came home from Korea. And he likes him. Everybody in town knows Jerry. Everybody knows that he drinks too much. And everybody likes him.

Tonight the deputy has just performed a familiar ritual. Hundreds of times before he has done the very same thing. Except, before he always called Jerry's mother; or Doctor Lamb, the family physician; or Father Daunt, the local priest who works with alcoholics.

Tonight the deputy called no one. And at one o'clock in the morning of February 4, 1977, Jerry Kuhlow will die in D.T.'s.

. . . .

For how long can we say no one cared?

CONCLUSIONS

—Compulsive behavior related to substance abuse, *e.g.* alcoholism, is irreversible without effective and efficient intervention and leads to losses in family, friends, and employment; as well as to a loss of self–respect, freedom, and finally life itself.

—Efficient intervention is to arrest the behavior immediately by a change of environment in terms of working and/or living conditions.

—Effective intervention is based on non–productive behavior, distinguished from what may appear to be character or personality deficiencies.

—Responsibility and self–respect are most effectively and efficiently restored within the context and with the support of the therapeutic community; whether a professional community, such as an encounter group or A.A., or a nonprofessional group, such as the family or colleagues.

—It is not initially necessary for the subject to "want help" in order for the intervention and subsequent therapy to be beneficial.

. . . .

As an afterthought:

—God so loved the world that He made an effective and efficient (?) intervention and established a therapeutic community—the Church.

THE CHAPLAIN AND THE ARMY'S DRUG AND ALCOHOL ABUSE PROGRAM

Chaplain (MAJ) H. Harrell Hicks

Nearly six years ago, on 17 June 1971, President Richard Nixon declared a national counter offensive against drug abuse, which he termed "public enemy number one." Three months later, the Department of the Army created the *Army Drug and Alcohol Prevention and Control Program* (ADAPCP) to deal with the abuse of alcohol and other drugs by American soldiers throughout the world. As they still are today, the objectives were: to make a sustained effort to prevent alcohol and drug abuse; to attempt to restore to effective and reliable functioning those individuals with problems attributed to alcohol and other drugs; and to eliminate from the service those who could not be restored effectively in a reasonable time.

The primary functions of the Army's program are:

—*Prevention* through education, law enforcement, and community action;

—*Identification* through a variety of methods including voluntary, biochemical urine testing, and command, medical, and law enforcement reports;

—*Detoxification and Treatment* in medical facilities when necessary;

—*Rehabilitation* conducted in two phases—active and follow–up.

Clinical confirmation of substance abuse is mandatory before an individual can enter the rehabilitation program. The active phase of rehabilitation is normally sixty days and may be on a resident or non–resident basis, depending on the needs of the client. Individuals who do not respond to treatment and rehabilitation efforts during the active phase are processed for separation from the service. An individual who successfully completes the active phase, however, enters a 300–day follow–up period. The therapy for rehabilitation progresses from frequent counseling sessions during the active phase—individual, group, or both—to a reduced intensity during the follow–up term. The client's

Chaplain Hicks is presently assigned to the Army Staff, Office of the Deputy Chief of Staff for Personnel (ODCSPER). He works in the Alcohol and Drug Prevention and Control Policy Office. His background includes three years with the ADAPCP at Fort Sill, Oklahoma.

commander is to be closely affiliated with and participating in the rehabilitation effort throughout the year.

The Army knew, of course, that chaplains were actively involved in the area of substance–abuse treatment even before the Presidential Directive, Public Law 92–129, or the DoD Directive (1300.11) which resulted in the establishment of the ADAPCP. In Viet Nam and Europe chaplains centered their concern on drugs other than alcohol. Marijuana, hashish, barbiturates, amphetamines, and heroin demanded most of their attention. In the United States they began to concentrate on alcohol abuse among returning Viet Nam veterans and other personnel. And in Korea they became involved in both aspects of the problem as it affected service personnel. It was because of this background, which resulted in valuable experience and knowledge, that chaplains were regularly included as an active part of the staff when the response to chemical dependency became institutionalized.

With the development of the ADAPCP, Prevention and Control Teams were the initial concept of organization. The chaplain, along with medical and other personnel, participated in the educational and rehabilitation efforts of the program. Later, as data developed, experiences broadened, and lessons were learned, the Army began to employ civilian rehabilitation counselors within the United States who were supplemented by appropriate military personnel. Now, as the program has evolved, only a very few chaplains are officially associated on a full–time basis with the ADAPCP staff.

The responsibilities of those few chaplains are spelled out in paragraph 1–12g, Army Regulation 600–85, *Alcohol and Drug Abuse Prevention and Control Program* (1 September 1976):

> The ADAPCP Chaplain will:
>
> —Be assigned duties within the ADAPCP staff consistent with his primary role as a minister of religion;
>
> —Serve as the advisor to the ADAPCP staff on spiritual and religious concerns;
>
> —Participate in individual group counseling and talk sessions and, if properly trained, serve as group leader;
>
> —Plan and present, in coordination with the Education Coordinator, training and preventive education programs;
>
> —Maintain liaison and coordination with the installation chaplain and assist in the education and training of chaplains and in the development and presentation of programs which support the ADAPCP effort;
>
> —Advise on the ethical implications of the ADAPCP plans and policies;
>
> —Coordinate the use of installation chaplains in support of rehabilitation facilities and referral agencies;
>
> —Support the client and the ADAPCP staff through his right of privileged communication.

Recognizing that the right of privileged communications comes

into question, particularly in the event of voluntary (self) identification, the regulation addresses that point in the following manner:

> 3–3a . . . Normally, members with an alcohol or other drug problem should seek help from their unit commander; however, they may initially request help from their installation ADAPCP or medical treatment facility, a chaplain, or any officer or noncommissioned officer in their chain of command. If a servicemember initially seeks help from an activity or individual other than his/her commander, the individual contacted will immediately notify the servicemember's unit commander and installation Alcohol Drug Control Officer.
>
> b. The requirement that the individual contacted must notify the servicemember's unit commander and installation Alcohol Drug Control Officer is not in conflict with a chaplain's right of privileged communication. The situation in which the *servicemember is seeking assistance* from the ADAPCP is addressed in "a" above, but the situation in which the *member merely reveals* to a chaplain that he/she is abusing or has abused alcohol or other drugs is not addressed. In the latter instance, it is expected that the chaplain would inform the member that—
>
> (1) Professional alcohol/drug treatment and rehabilitation counseling is available through the ADAPCP;
>
> (2) The Army program requires that the member's unit commander become involved in the rehabilitation process; and
>
> (3) The chaplain cannot assist the member's entry into the ADAPCP without going through the member's unit commander.*

Acknowledging the fact that only a limited number of chaplains will now work in the roles described in that regulation, the immediate questions are:

—What is the role or the participation of the chaplain who is not assigned to the ADAPCP staff?

—Does the chaplain have any responsibility to fulfill?

—Does the chaplain have any method of making a significant impact in the area of substance abuse?

Perhaps the initial answers to those questions are found in the Army's expectations of the chaplain in community involvement. Note paragraph 2–14 of the same regulation:

> One of the few staff officers on an installation having access to all levels of the community is the chaplain. Through his unique relationship with the commander, members of the command, and their families, the chaplain serves as a positive influence in the ADAPCP. Using the guidelines established in AR 165–20 and in FM 16–5, the installation chaplain should—
>
> —Serve as a member of the Alcohol and Drug Dependency Intervention Council or other council which addresses alcohol and other drug abuse matters.
>
> —Provide chaplain coverage as appropriate to the ADAPCP.
>
> —Insure contact and maintenance of relationship with local

*AR 600–85; paragraph 3–3a,b (emphasis by author).

clergy, veterans' organizations, civic organizations, religious and professional organizations within the civilian sector.

—Facilitate the development of spiritual, social, and moral aspects of community life that provide constructive alternatives to the abuse of alcohol and other drug abuse.

—Initiate corrective or supportive actions and recommend material resources and policy changes within the Human Self–Development Program as it relates to the ADAPCP (AR 600–30).

—Advise the commander on the ethical and moral implications of the ADAPCP plans and policies.

Even though those words specifically address the installation chaplain, the same basic guidelines are applicable and helpful for the unit, hospital, confinement facility, special assignment, or other chaplain.

To be more specific, the question of chaplain responsibility to function in the areas of substance abuse is answered in the serious acceptance of the prophetic nature of the ministry. We cannot neglect the fact that alcohol and other drug abuse is *still* a major problem area in the armed forces. From a military standpoint we know substance abuse impairs the readiness of the forces and their ability to accomplish given missions. Even more important, however, are the detrimental effects on individual people—the damage to personal health, the injury to others while under the influence, the consequences of legal prosecution, the tragic disruption of families, etc. Speaking to those kinds of concerns for the individual and the total military community is a *prophetic* responsibility of the chaplain. The chaplain can accomplish this in a variety of means—as a member of councils which address the issue of alcohol and other drug abuse, as a concerned and perceptive advisor to the commander, as a leader in the Human Self–Development Program, as a preacher vividly aware of human needs, or as an innovator of new methods.

After many years of experience, it is evident that the Army is never going to eliminate substance abuse. Realistically, the present approach calls for an effort to increase awareness of the problem and to encourage conscious, responsibile decisions regarding substances which have injurous effects on the individual and community when abused. The chaplain holds one of the most advantageous positions to foster such preventative education, to insure that personnel do not use drugs out of ignorance of their effects.

This is a natural arena for the chaplain. Few people within the military system have as much opportunity to do preventative education in a diverse variety of areas, including substance abuse. From my experience, it's possible through numerous means, *e.g.*, talking openly about the problem with individuals at every level of the military structure, dealing with it in formal classes, in counseling sessions, worship

services, and social gatherings. Through a variety of innovative ways the chaplain can provide knowledge of the alternatives to substance abuse and information and help in personal decision making and values' clarification.

Recognizing that work as a preventative educator or supporter of the ADAPCP staff is still another duty for an already busy schedule, the chaplain may ask:

"What are the benefits of my helping the ADAPCP when I'm not assigned there and they already have a whole staff of people?"

While it's impossible to give a definitive listing of such benefits, my personal experience with ADAPCP staff members, clients, commanders, and other chaplains associated with the program attests to the fact that there are many. They include the advancement of the chaplain's own education in dealing with substance abuse, knowledge of referral resources, and, tangentially, community awareness of the chaplain's interest in the quality of human life.

I recognize there will always be different levels of interest and involvement between chaplains and ADAPCP. For some it will be strong, for others minimal, and for still others non–existent. Differences in beliefs, philosophies, and personalities will have an effect upon those decisions. But those who decide to have an active role and take time to establish a supportive relationship with the ADAPCP will discover new and effective tools for their own ministry—tools that can help the victims of a commonly neglected disorder in the military community.

THE CHAPLAIN'S RESPONSIBILITY TO THE ALCOHOLIC: A RETHOUGHT

Vernon E. Johnson, D.D.

In my experience with training military chaplains who are attempting to offer counsel to alcoholics, or other chemically dependent persons, I have become aware of how frustrated many of them are with this part of their work. Classically, the alcoholic presents such a rigid and thoroughgoing denial of his condition that there seems to be no adequate way to offer "help." How can one help someone who does not want help?

There seem to be two factors in most situations presenting themselves to chaplains which mitigate against effective counseling. First is the very nature of the disease. As it moves through its progressive stages, the victim is rendered more and more *incapable* of recognizing either the presence of his symptoms or the severity of them. The fact is that, as the alcoholic's behavior becomes more and more compulsive and bizaare, his memory of those behaviors is increasingly distorted.

This distortion is composed of three components. First are the blackouts which are increasing in frequency. A blackout is a form of chemically induced amnesia during which the individual functions as though he is remembering all that is occurring when, in reality, he will not be able to remember any of that period of time. Many times some of the most destructive behavior occurs during a blackout and, therefore, is unavailable as data to help the alcoholic to recognize the seriousness of the chemical abuse.

Secondly, repression acts to hide from the conscious mind of the alcoholic those memories of drunken behavior which are acutely painful or shameful. In this way the alcoholic spontaneously "forgets" the discomforting events of "the night before."

Finally, euphoric recall plays havoc with what was remembered about "last night." Euphoric recall refers to the phenomenon in which a person remembers the feelings of intoxication rather than the behaviors of intoxication. In this way the alcoholic truly believes that drinking is fun and that he is the "life" of all the parties. Others, however, who have

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witnessed his "party behavior" remember his slurred speech, spilled drinks, and his loud and off–color jokes. Once again, he is unable to recognize the harmful consequences that his drinking is causing himself and others.

Added to this confusion and gross distortion are his psychological defense systems. These systems, which always operate at an unconscious level, take over to handle his increasing distress with himself and his life situations.

Rationalizations and projections, starting out logically and relatively harmlessly, progress out of need to explain what is happening to him, and eventually develop into what are pathologic proportions. In due time he *believes* what to others who see him is *unbelieveable*. He is deluded—sincerely deluded and out of touch with the reality of his situation. "I don't drink any more than, or any differently from the rest of the people around me!"

The second factor, limiting the effectiveness of many of the efforts of the chaplain to counsel the alcoholic, is the fact that often he finds himself at the outset in a one–to–one situation with the alcoholic who has been sent "to see the chaplain." It makes little difference whether the sender is a commanding officer, spouse, or other person, since usually those persons do not see themselves as directly involved. The chaplain is to "fix" it; it is his job to motivate the alcoholic to seek the appropriate type of continuing care.

In such situations, the chaplain is severely handicapped. He lacks sufficient specific data to evaluate the progression of the illness, as well as the "clout" to insist on remedial care. He must depend on the personal insight and self–diagnosis of the victim, which by definition is, at the very least, unlikely! Or he must rely on his own intuition and skills at moral suasion. Again, at best, the outcome remains dubious!

In addition, because the primary problem of alcoholism cannot be identified, confronted and dealt with, the chaplain is often manipulated into believing that "other problems" are really the source of dysfunction for the individual. This perception of the situation, in turn, leads the chaplain to attempt to help the individual solve those many other problems that are presented by the alcoholic, such as: rocky marriage relationships, poor job performance, deteriorating health, etc. Since these problem areas are all related to or caused by the compulsive and abusive drinking pattern, any success in their reduction lasts only until the next drinking bout. This, of course, results in growing feelings of frustration and then hopelessness for all concerned.

How then can the chaplain be useful? Is there a process he can introduce and guide with some real expectation of a successful result? The answer seems clearly to be affirmative, and it begins with the

abandonment of the attempt to work directly with the denial of the alcoholic on a one–to–one basis.

IDENTIFY THE ILLNESS

Instead, the chaplain needs to work with those persons who surround the alcoholic and have a growing concern about his drinking pattern. It is these persons who have significant and sufficient data regarding the alcoholic's growing harmful alcohol dependency. From these data the chaplain is able to get a clear and realistic picture of the individual's drinking pattern. Having gathered these data and having recognized the presence of alcoholism, the chaplain would then proceed as follows:

GATHER THE CONCERNED PERSONS

These persons are chosen because they (1) exercise influence on the identified chemically dependent person, and (2) they possess the data which can identify the presence of alcoholism. With the formation of this group (two, three or more persons) the chaplain can begin a series of intervention training sessions.

INTERVENTION TRAINING OF THE KEY PERSONS

These sessions have two basic goals:

1. The first goal is evaluate these people in two areas:

A. Do they know enough about the nature of alcoholism to accept the basic facts that the alcoholic is incapable of recognizing the true nature of the disease and, therefore, is unable to seek help voluntarily? At this point the chaplain would present basic information about the psychological, emotional, physical and spiritual symptoms of the disease. Emphasis would be placed on the sincere self–deceptions that victimize the alcoholic. The chaplain would thoroughly describe the nature and effect of defense systems such as rationalizations, projections, and denials. Included here would be explanations of the concepts of blackouts, repression, and euphoric recall which combine to form massive distortions within the alcoholic's memory system.*

All of this information assists the concerned persons to realize that the alcoholic is out of touch with the reality and severity of the symptoms of the disease. The alcoholic *cannot* rather than will not seek help. Help must come from the outside. . . they must intervene.

B. Are these people emotionally adequate to be interveners? The chaplain needs to be sensitive to the characteristic immobilizing fear that many interveners feel when they think about confronting the alcoholic with the self–destructive drinking behavior. This fear is described in such typical statements as:

*For a detailed description of the nature and dynamics of alcoholism see, Vernon E. Johnson, *I'll Quit Tomorrow* (New York: Harper & Row, 1973).

—"If I do this, will he divorce me?"
—"He probably will never speak to me again."
—"Who am I to tell him how he should drink?"
—"I don't think I should butt into his personal affairs."

Most interveners are able to work through much of this immobilizing fear by recognizing and then accepting the fact that they are dealing with a progressive condition which, if they do nothing, will lead inevitably to the alcoholic's premature death. They, therefore, are able to see their choices as:

1. Risking a deteriorating relationship by intervening, or
2. Doing nothing and watching the alcoholic continue to die slowly.

For most concerned persons the knowledge they receive from the chaplain and the support they gain from the other group members is enough to stabilize them emotionally. This, in turn, allows them to be able to present themselves and their data about the addiction to the alcoholic at a deep level of concern. If, however, a group member continues to be overly fearful or judgmental, then the chaplain should have serious reservations regarding this person's effectiveness as an intervener, and move to exclude that person from the group!

2. The second goal of the chaplain, after the evaluation, is to prepare these people specifically for the intervention scene. To do this, the chaplain needs to make certain that the group has a thorough understanding of the intervention process and the role that they play in that process. Specifically, the chaplain should prepare this group to be able to:

A. Equip themselves with *written* lists of specific incidents or conditions (of which they have been first hand observers preferably) which legitimatize their concern for the severity of the situation. The chaplain is to emphasize that generalizations are not useful––example:

"You have to stop drinking" or "The drinking is getting worse" or "You're gone almost all the time," and the like.

Rather, they should be equipped to say that, "Last Thursday night at 8:00 you came in slurring your words and knocked over and broke the lamp on our livingroom table. Perhaps you do not remember that because you were obviously under the influence." Not only are the incidents to be specific, but they are to be explicitly presented. That is, they describe his *condition* at the time.

B. These data are to represent the *legitimacy of the concern* which is being expressed and each presentation could typically begin with the phrase, "Another reason I have been concerned is that last Saturday night . . ."

C. The group itself should now become familiar with various alternatives in the continuum of care which could be offered to the alcoholic. Based on the severity of the symptoms that the alcoholic is presenting, they should then agree which alternatives will be offered. They, however, should be aware of the need to press for a "What if" clause agreement should the alcoholic reject all of their alternatives on the claim that "I can quit on my own." By getting the alcoholic's committment to accept their alternative if this self–remedy fails, they have outlined a definite course of action should a resumption of drinking occur. By exploring all of these alternatives, they have gained group support, unity of purpose, and a specific goal to be achieved during the intervention session.

D. At this point, the group should predict what will be the alcoholic's most likely excuses for not accepting the choices being offered and attempt to meet them in advance. Examples: "I can't go to treatment now because my work will not allow me to be absent" or "I can't go to treatment now because there is a very important family commitment we have made" and the like. When the group is prepared in advance to answer such excuses, the likelihood of his accepting treatment is greatly enhanced.

E. Finally, the chaplain should rehearse the group by simulating the forthcoming intervention session. This session would not require the individual group members to report specifically the data that they had written on their lists. Rather this session is designed to answer any last questions about the future intervention session. Also, since the group members already have their lists of data prepared, the chaplain can ask them to review them once more and make sure that the data is all specific in nature and tied directly to the drinking. Lastly, during this session, the chaplain needs to select a chairperson for the group and to define his role. The chairperson is chosen because he (or she) is the most influential with the identified alcoholic. This person, very often, will be instrumental in seeing to it that the alcoholic will be present at the time and place appointed.

The chaplain will instruct the chairperson in the following duties:

1. Open the meeting by stating clearly and directly *what its purpose is*. "Joe, we have asked you to meet us today because we feel that it is necessary for us to share with you a specific concern we all have about your health."

2. Summarize how these people were gathered for this purpose. "So–and–so went to the chaplain because his concern had become so great that we wanted counsel. The chaplain in turn called the rest of us in and we planned how we could most usefully share our concerns with you. That's what brought us together today."

3. Set the ground rules for the meeting. The chairperson is to make it clear to the alcoholic that each group member would like the opportunity to present his concerns without interruption. After all the group members have finished, then the alcoholic would have an opportunity to respond. It is important that the alcoholic, chairperson, and the group understand that this session is not a debate nor is it a trial. Rather, it is a form of discussion in which a group of sincere people can present their legitimate concerns about the health and welfare of someone they care about. It is important that the alcoholic be exposed to the full impact of the severity of the disease as it is expressed to him through those persons who are most meaningful to him. For this reason, the chairperson is instructed to interrupt any verbal entries by the alcoholic during the course of the meeting so that his "listener" stance is clearly kept.

4. Lead the process of the presentation of the data by indicating the order of their presentations. "Sir, it would be helpful, I believe, if we began with your material on why you, as commanding officer, have become concerned," or "Since this has involved a significant part of your relationship at home, would you please start, Mrs. Joe?" Likewise, others in the room are requested to share in turn with appropriate comment. "You're his buddy and you have become worried because . . ." "As the daughter you have been concerned for several years about this illness," etc. The chairperson will start with the person who is the most influential and who has the most descriptive data. He will use the person last who is capable of the greatest emotional appeal to the identified alcoholic.

5. Close the session by summarizing the concerns of the group and by offering the choices of care that the group has agreed upon in advance. "Joe, what we want you to do is to get some help. You have these forms of care available . . ." and here the alternatives are given. Firmness is required here from the chairperson as he represents the group's position. Reassurances and hope are the themes behind the firmness. "The service has a policy with this illness now. Your *career* is not in jeopardy *if* you accept help. This is a highly *treatable* disease and significant numbers have already gone through treatment successfully from all the ranks of the armed services."

With the referral of the alcoholic (and family members, if any) to the appropriate program of care, of which A.A., Alanon, and Alateen, are primary resources, the chaplain is to follow up to make certain contact is made. It is suggested, in fact, that the primary contact for referral be made by the chaplain's office itself. From this point on, the chaplain is now able to focus on providing aftercare counsel and support to both the alcoholic and concerned persons.

In summary, then, since the nature of the disease of alcoholism, or more generally, chemical dependency, is such that the victim is rendered increasingly incapable of offering himself to remedial care *spontaneously*, the process called intervention is to be viewed as the norm rather than the exception. Carefully prepared and conducted, interventions have a history now of breaking through the denials and bringing many people to appropriate care.

One final, but most important point needs mention. If interventions are going to occur in the armed services in significant numbers, it will be because an environment of understanding of the nature of the illness has been developed. Obviously, this speaks to a program of continued education for service personnel and their families. The chaplain's office would seem to be the logical and useful focal point for such educational efforts. The Department of Defense has developed a film library to assist in this process.* Pamphlets and other literature are readily available. As understanding increases, interventions are seen to be a normal form of dealing with the afflicted. The chaplains, in turn, move from previous frustration to the new satisfaction of being part of a process in which lives are saved and careers restored.

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*The film, *I'll Quit Tomorrow*, is now available through the Department of Defense and is designed to be directly descriptive of *Intervention with the Alcoholic*.

PRIESTS AND ALCOHOL

Joseph H. Fichter

The most vocal leaders of the various temperance movements have been clergymen who were concerned about the moral behavior of their people and who fought public battles against "Demon Rum." It may seem indelicate then to investigate the drinking habits of the men of God, who are expected to be models of sobriety. To go a step further by inquiring about alcoholism among the clergy may appear to be disloyal, yet experts emphatically assure us that no occupation or profession is exempt from the ravages of this three-pronged illnes of body, mind and soul.[1]

The notion that partaking of alcoholic beverages is sinful in any form—often attributed to the Puritan and Calvinist ethic—was not always acceptable to Protestants. In their recent overview of colonial America, Conley and Sorensen recall that Baptist and Methodist preachers were not above operating whiskey stills and there was a certain amount of "tippling" among Protestant ministers of that period. "By the nineteenth century, many cases of drunkenness on the part of ministers began to be recorded—and this more frequent mention of intoxication among clergymen probably indicates that in fact it was becoming a greater problem." [2]

Early temperance groups in Ireland preached "moderation" in drinking, but when they began to make total abstinence their goal Catholics opposed it as a "heresy imported from abroad," an inspiration from American Protestants, especially in the form of Lyman Beecher's sermons on *The Evils of Intemperance*, circulated widely in Ulster

[1] With the concept of alcoholism as a sickness there is also an insistence that only a small percentage of alcoholics are living on Skid Row.

[2] Paul Conley and Andrew Sorensen, *The Staggering Steeple: The Story of Alcoholism and the Churches* (Philadelphia: Pilgrim Press, 1971) p. 26.

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beginning in 1828. Irish Protestants too were reluctant to accept total abstinence, especially when they saw some of their own clergymen given to drink. According to one report, congregations were unimpressed by "drunken ministers reasoning from their pulpits of righteousness, temperance and the judgment to come." [3]

Historians point out there had been no serious drinking problem in the colonies before the American revolution, as compared to widespread drunkenness in England. This era of American moderate drinking ended in the turmoil of the new republic.

> Perhaps nothing illustrates the tolerance of excessive drinking in the late eighteenth century as much as the heavy use of whiskey at ministerial ordinations, where considerable drinking and frequent drunkenness became customary. This was so much a feature of ministerial conduct that those who tried to apply the earlier norms of moderation were liable to criticism by superiors.[4]

REFORMERS WERE SOBER

When the temperance movement got under way, its clergy leaders were not reformed alcoholics, attempting to mend their ways. They and their colleagues among the laity—especially those who later formed the Women's Christian Temperance Union—were sober citizens who deplored alcohol as a personal and social evil. In a pastoral letter, the bishops of the Third Plenary Council of Baltimore in 1884 wrote:

> It is a mistake to imagine that such societies are made up of reformed victims of intemperance. They should be, and we trust that they everywhere are largely composed of zealous Catholics who were never tainted by that vice, but who mourn over the great evil and are energetically endeavoring to correct it.[5]

Among the priests who spearheaded the Catholic Total Abstinence Union there was one exception to this episcopal generalization. The first president of this Union was Father James McDevitt, whose "interest in the movement seems to have had its source in personal need." His bishop later said about him that "some years ago, he got into the habit of drinking too much, but reformed, and was doing well." Father McDevitt gave so much time to the Union he neglected his duties as parish priest and was advised by his bishop to resign the presidency. He withdrew from the diocese, but was later reinstated. He died in his rectory in Baltimore while the twenty–fifth annual convention of the Union was in session in 1895. "There was no mention of him in the proceedings of the convention." [6]

Only clergymen could hold the two top offices of the Catholic

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[3] This is quoted from Rev. Dr. Edgar of Belfast, Presbyterian professor of Theology, by Patrick Rogers, *Father Theobald Mathew*, (New York: Longmans, Green, 1945) p. 31.

[4] Joseph Gusfield, *Symbolic Crusade* (Urbana: University of Illinois Press, 1963) p. 38.

[5] Quoted in Joan Bland, *Hibernian Crusade* (dissertation at Catholic University, 1951) p. 122, who cites it from Peter Guilday, ed., *The National Pastorals of the American Hierarchy*. 1792–1919 (Washington, 1923) p. 261.

[6] Bland, *Hibernian Crusade*, pp. 64, 78, 205.

Total Abstinence Union and they, like all the members, were required to pledge: "I promise, with the Divine assistance, and in honor of the sacred thirst and agony of our Saviour, to abstain from all intoxicating drinks; to prevent as much as possible, by advice and example, the sin of intemperance in others, and to discountenance the drinking customs of society." [7] Not until 1903 was a separate national organization established for priests. This was the Sacerdotal Abstinence League which grew out of a group in Cincinnati, the Sacred Heart Priests' League for the promotion of Total Abstinence. The founders insisted, however, this was not intended for the reform of priests who drank too much.[8]

By and large then the early temperance movements, both Catholic and Protestant, were made up of people who wanted to reform other people. Exceptions to this generalization, not led by clergymen, were the Good Templars, the Sons of Temperance, and especially the so–called "Washingtonians." [9] This latter group, formed in the nation's capital in 1840, was made up of reformed drunkards who freely told their alcoholic experiences and had no official church connections. "In their evangelical techniques, indifference to theology, and vulgar identification with the manners and language of the masses, they were anathema to the more conservative and sedate leaders of the earlier movement." [10]

ADMITTING ALCOHOLISM IS HARD

Whatever the drinking habits of Catholics may have been in the past, the early zeal of temperance and abstinence organizations seemed to have abated with the national prohibition experiment and its aftermath. The reluctance to admit that clergymen may have a drinking problem was widespread as long as moral stigma was attached to such behavior. To the extent that this moral and social stigma is still attached to the alcoholic person, its negative connotation is magnified in the case of the man of God. As late as 1967, in an otherwise sympathetic article about alcoholic clergy, Pirone used the pejorative term, "fallen priests," but regretted "there are still many church officials who treat the problem of their drinking priests as strictly a moral issue, not as a disease." [11]

The first alcoholic priest, known to have become a participating member of Alcoholics Anonymous, was the late Father Ralph Pfau, who wrote:

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[7] *Ibid.*, p. 82.

[8] *Ibid.*, p. 231. See also Edward McSweeney, "Apologia Pro Foedere Abstinentiae," *American Ecclesiastical Review*, Vol. XXX, March, 1904, pp. 241–257.

[9] See John Krout, *The Origins of Prohibition* (New York: Knopf, 1925).

[10] Gusfield, *Symolic Crusade*, p. 49, and footnote 29, where he remarks about the "anticlerical nature of the Washingtonians."

[11] Jean Pitrone, "Drinking Priests," *U. S. Catholic*, January, 1967, pp. 39–43.

> Admitting that I am an alcoholic did not come easy; it never does. I always thought that an alcoholic had to be a lost soul, a beaten, forgotten man, a rum-soaked derelict who drank himself into a perpetual stupor and who, because he drank liquor instead of eating food, finally died in a gutter of cirrhosis of the liver, or some such dreadful ailment. To me, he had to be at least unmoral, if not downright immoral, unable to control his lust for liquor because his will was weak. And, since I was not that way, I couldn't believe that I was an alcoholic.[12]

If Father Mathew was the Apostle of Temperance a century earlier, Father Pfau was the anonymous "Father John Doe" who gave spiritual retreats to equally anonymous people, both Protestants and Catholics, and separately for males and females. From 1943, when he joined A. A., until his death in 1967, he also gave lectures at meetings and conventions of A. A., as well as to many other groups.[13] His ventures into this unchartered area brought opposition from two directions. Some of the A. A. feared he was trying to convert them to Catholicism. When he sought a location to give weekend retreats he tried several Catholic institutions. "Oh no, Father, not here," was the inevitable reply.[14] The well-established houses of retreat were reluctant to associate themselves with alcoholics, even if they were priests.

Traveling as he did Father Pfau made contact with other priests with drinking problems and tried to gather them for a spiritual retreat. Out of this came the establishment of the National Clergy Council on Alcoholism which held its first annual meeting in August, 1949. The shroud of silence and shame that surrounded the existence of alcoholic priests was finally lifted. Bishops and other superiors were fully informed of this event, and the result has been a kind of open and official Catholic recognition of the problem of alcoholism among clergy.

MEETINGS ARE OPEN

From the beginning this organization had an episcopal advisor, a board of directors and an advisory board composed exclusively of clergymen. The annual conference "deals primarily with priests' personal problems. Consequently its sessions are not to be publicized although they are open to all priests who take an interest in these special problems. Laymen may attend only by special invitation from the Board of Directors." [15] In 1959 the Council inaugurated the annual Pastoral Institute which deals only with the professional problems of priests. "Its sessions are publicized and are open to all priests and students of theology in major seminaries."

[12] Father John Doe, *Prodigal Shepherd* (Indianapolis: SMT Guild, 1957) p. 11. After his death in 1967 his book was revealed as having been written by Ralph Pfau with the assistance of Al Hirshberg.

[13] His inspirational talks were published anonymously over the years and called *The Golden Books*, which then became the contents of Father John Doe, *Sobriety and Beyond* (Indianapolis: SMT Guild, 1955). This book has a sequel, Father John Doe, *Sobriety Without End* (Indianapolis: SMT Guild, 1957). He also produced a set of thirty recordings, mainly on the spiritual aspects of rehabilitation, which are still in wide distribution.

[14] *Prodigal Shepherd*, p. 217.

[15] *The Blue Book*, Vol. XIX, 1967, p. x.

The extent to which this Council moved from its cautious, exclusive beginnings to its present open, well–publicized meetings is a measure of the willingness of the American Catholic Church to recognize the problem of alcoholism. The twenty–seventh annual conference in 1975 revealed that the membership, as well as the board of directors, included lay persons, religious sisters and brothers, as well as priests. Attention is being paid to other addictions and the title has been changed to the National Clergy Council on Alcoholism and Related Drug Problems. The annual meetings are published in *The Blue Book*,[16] a valuable source of information about the modern Catholic approach to a previously embarrassing problem.

The National Clergy Conference is in no way a competitor of Alcoholics Anonymous; it is not a modern version of the Total Abstinence Union, nor a revival of prohibitionists and anti–saloon leaguers. As late as 1974, however, the executive director had to call attention to "the fact that many people still have the image of the NCCA as an organization for clergy suffering from alcoholism. This is *not* the make–up of the NCCA. We are an organization for *all* clergy and religious men and women of the United States." He also noted the greater effort put "into clergy and religious involvement in the alcohol and drug abuse problems among the laity." [17]

The fourfold objective of this Catholic Clergy Council is: a) Education of Catholic clergy through an annual pastoral conference on alcoholic problems; b) Prevention of alcoholism through dissemination of information and through an educational program, especially in seminaries; c) Recovery of alcoholics through the Sacraments of the Church and the program of Alcoholics Anonymous; d) Cooperation with the Most Reverend Ordinaries and with all organizations working in the alcohol field for the promotion of these purposes.[18]

Father Pfau found his therapy mainly in the program of the A. A. fellowship into which he introduced other alcoholic priests, some of whom had been unsuccessfully hospitalized for treatment. He wrote, "the present methods of dealing with the problem (with the possible exception of the almost miraculous work of Alcoholics Anonymous), are in many cases expensive, sometimes barbaric; almost always punitive; and they seldom rehabilitate nor do they prevent." [19] There have been large improvements in treatment since the early 1950's when he made these complaints, yet there remains the problem of restoring alcoholics to a useful, healthy and normal way of life.

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[16] Father Pfau gave it this title to distinguish it from the series of pamphlets he had been publishing, which came to be known as *The Golden Books*.

[17] Remarks of John Cunningham, *The Blue Book*, Vol. XXVI, 1974, p. xvi.

[18] These aims are listed in *The Blue Book*, Vol. XXV, 1973, p. vi.

[19] Father John Doe, *Sobriety and Beyond* (Indianapolis: SMT Guild, 1955) p. 7.

While alcoholic clergy were enormously helped by spiritual programs for continuing sobriety there arose the debate whether special facilities should be instituted for the treatment and rehabilitation of alcoholic priests. The protagonist for this view, and the founder of the Guest House sanatoria, was Austin Ripley, a devout Catholic alcoholic layman. He had a deepfelt respect for the priesthood and a genuine sympathy for those suffering the problems he had endured. At first he brought the sick priest into his home and tried to help on the basis of his experience in alcoholic recovery. After assisting a small number of priests in this way, with very little success, he rented an unused convent as a sanatorium.

CLERGY NEED SPECIAL FACILITIES

Ripley faced objections from two directions. One was from those who believed alcoholism is no respecter of persons or status and the alcoholic should be treated as a sick individual, not as one who is in a particular occupation or profession. Most large rehabilitation centers, especially those under public auspices, follow this policy of admitting patients regardless of sex, age, occupation or social class. McIllwain tells that his fellow patients at the Alcoholic Rehabilitation Center in North Carolina included "all sorts," from college students to grandmothers, from well–educated professionals to manual workers.[20]

If alcoholism is placed in the category of illness it is logically a "leveler" for all those who suffer from it. Hospitals treat people according to the disease they suffer and logically give the same treatment to all who have the same illness. Roman remarks that a kind of "populism" is in "much of the alcohol–problem field which in turn may have its roots in the precepts of Alcoholics Anonymous." [21] There is a democratic openness characteristic of A. A. fellowship where "the only requirement for membership is a desire to stop drinking."

Austin Ripley stood against this "populist" generalization when he insisted on special treatment facilities for the clergy, and evidence is now accumulating in support of his thesis. In industry and government, alcoholics at the managerial level resist treatment in the same program with alcoholics at the level of the shop and assembly line. The military finds separate programs for officers and soldiers more satisfactory than a program that attempts to treat both. Many priests who attend A.A. groups prefer to dress in civilian garb, reluctant to identify themselves as clergymen. Larger urban dioceses sponsor A. A. groups for priests only; New York had one as early as 1956; Chicago continues to promote

[20] William McIllwain, *A Farewell to Alcohol* (New York: Random House, 1971) pp. 9f. The question of separate treatment facilities for clergy alcoholics was thoroughly discussed in 1969 by a panel of national treatment center directors. See "Alcoholism—Priest and Laity," *The Blue Book*, Vol. XXI, 1969, pp. 53–70.

[21] Paul Roman, "Spirits at Work Revisited: Needed Priorities in Occupational Alcoholism Programming," paper read at Conference on Alcoholism of NIAAA, June, 1974, p. 10.

such groups under its well–developed program on alcoholism.

PIUS XII SUPPORTED RIPLEY

The second objection encountered by Ripley came from the local bishop (and some other hierarchs) who felt a special treatment facility for priests—especially one that was not under ecclesiastical control—would give unfavorable publicity to an already "shameful" problem. Bishop Treacy, of La Crosse, locked Ripley's first institution, ordered him off diocesan property, and forbade priests to participate in the program. Ripley persuaded a canon lawyer to represent his case to Pope Pius XII in Rome by whom he was vindicated. According to Ripley's memoirs, the Holy Father personally requested Cardinal Stritch of Chicago and Cardinal Mooney to support Ripley and Guest House.[22]

The Detroit Cardinal invited Ripley to establish the Guest House in his archdiocese, endorsed his concept of lay ownership and management, gave him financial support and later loaned him funds to purchase the Scripps estate at Lake Orion, Michigan. Ripley dissolved the previous Guest House corporations in Minnesota and Wisconsin, and together with two other A. A. lay persons formed a new Michigan non–profit corporation. He opened the doors of Guest House in May, 1956, and broke ground for a second facility in 1967 at Rochester, Minnesota, in the shadow of the Mayo Clinic. From the time of his retirement, due to illness in 1968, until his death in 1974, he spent much of his limited energy trying to promote interest in a treatment facility for alcoholic religious sisters. He did not succeed.

Between Father Pfau's National Clergy Council on Alcoholism and Austin Ripley's Guest House, there developed a growing conviction among Catholics that something should, and could, be done about alcoholic priests. This "hidden" problem has been brought more and more into open discussion. A stream of literature about alcoholism is being produced, and it is unfair to say with Arthur Cain that "few fields of inquiry in the entire human endeavor have had so much written about them—with so little to say." [23] Vander Veldt and McAllister remarked in 1962 that "earlier publications related specifically to the problems of alcoholism in a group of clergymen have not come to our attention." [24] More recently Sorensen did a doctoral dissertation at Yale on a small sample of Catholic and Episcopal alcoholic priests.[25]

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[22] There are many anecdotes, not yet published, of Ripley's struggles with some members of the hierarchy. As his work proved successful he received various forms of recognition, like the Insignis Medal of Fordham University in 1966. See Henry Hammett, "Austin Ripley and Alcoholic Priests," *America* December 24–31, 1966, p. 831.

[23] Arthur Cain, *Paul King's Rebellion* (New York: John Day, 1967) p. 94.

[24] Albert Vander Veldt and Robert McAllister, "Psychiatric Illness in Hospitalized Clergy: Alcoholism" *Quarterly Journal of Studies on Alcohol*, Vol. 23, 1962, pp. 124–130.

[25] Andrew A. Sorensen, *The Development of Alcoholism Among Roman Catholic and Protestant Episcopal Clergymen* (Yale University dissertation, 1971).

HOW MANY INDULGE?

There are no reliable statistics showing the incidence of alcoholism among American Catholic clergy. Occasionally one hears of confidential surveys undertaken in some Catholic dioceses and religious orders, out of which conflicting reports emerge to circulate in the flow of rumor. Statistics seem to be used more loosely in the study of drinking habits—and of alcoholism—than in any area of social problems (with the possible exception of delinquency and crime.) Some obvious comparisons can be safely made. If Episcopalian and Catholic lay people drink it is to be expected that they condone drinking in the clergy. If Methodist and Baptist lay people have ethical qualms about drinking, they are most likely to condemn drinking in their clergy. It is logical to speculate, therefore, there is more drinking among urban Catholic priests than among rural Protestant ministers.

The complaint that we do not possess reliable drinking statistics on clergy is not meant to imply that there is solid information about people in other occupations. Everybody has heard that physicians drink a lot on weekends, that military officers can hold their liquor like gentlemen, that salesmen and seamen, bartenders and cocktail waitresses, and people in most other occupations (except ministers and priests) tend to do a great deal of social drinking. Here again, and for the most part, we do not have comparative information on drinking and alcoholism across occupational lines. There is some evidence that abstainers are numerous among farm owners, and non–abstainers among professional, semiprofessional, technical, sales and managerial groups.[26]

The drinking habits, and potential alcoholism, among the Catholic clergy may be viewed from the several specific variables that attach to the career priesthood. The first of these is that the theological and ethical training for the priesthood, as well as the life–style of the seminary, are pointed at a higher degree of religiosity, which tends to be correlated with habitual moderation, if not with total abstinence. Catholic seminaries, like dormitories in Church–related colleges, usually have regulations against the possession and use of liquor in students' rooms, although there may be occasional, or regular, service of beer or wine at meals. Sometimes a seminary faculty member promotes voluntary affiliation in a Catholic Temperance group. While seminary life is probably not as "rigorous" as it once was, the training for sobriety in general would still "prevent the problem from occurring or prevent the problem drinker from remaining in the seminary." [27]

There used to be a custom, which seems to have fallen into

[26] Don Cahalan, Ira Cisin and Helen Crossley, *American Drinking Patterns* (New Haven: College and University Press, 1969) pp. 29f.

[27] Vander Veldt and McAllister, "Psychiatric Illness in Clergy," p. 125.

disuse, to require the candidate for the diaconate to take a pledge of abstinence from liquor for a period of five years after ordination. Aside from spiritual motives, this was probably thought of as a preventive, or as a means of fostering sobriety. Whether or not this pledge is made, the young priest is faced with the unique fact that the sacramental use of wine is in his daily celebration of the Eucharist. In 1970 Russell Smith pointed out that "this single factor makes the alcoholic priests' recovery a special and more difficult achievement than that of any other group." [28]

USE GRAPE JUICE AT MASS?

Sacramental wines vary in alcoholic content, as Father Pfau discovered when he was tempted to a "slip" from abstinence.[29] During the height of the campaign for prohibition, one priest is said to have petitioned the Pope to permit the use of unfermented wine at Mass.[30] He was considered an "extremist" in his views, but in 1974 an authorization came from the Vatican Congregation for the Doctrine of the Faith permitting alcoholic priests to use unfermented grape juice in the Mass. With this change of regulations, priests with a drinking problem are no longer faced with the temptation of altar wine. It should be noted, however, that the use of wine is a regular element of Jewish religious services, but that there is no known incidence of alcoholism among Jewish rabbis.

WHAT INFLUENCE IS CELIBACY?

Celibacy too is a characteristic that distinguishes the Catholic priests from other clergy and from other professions. Previous surveys of drinking patterns show "the single and the divorced or separated had a higher proportion of heavy drinkers on the average than the married or widowed, both among men and women." [31] Marital status is interpreted as a factor of life adjustment, and one may expect that those whose marriage has ended in divorce or separation find themselves maladjusted.

We are talking here, however, of men whose sacerdotal commitment requires them to be unmarried. We may surmise that celibacy itself is a "factor of life adjustment" for which the priest has had more preparatory training than other people ever get in anticipation of marriage. The so–called "problem" of celibacy has been widely discussed as one of the reasons why a certain proportion of men have resigned from the priesthood. In a survey of diocesan priests in 1960 we asked the

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[28] Russell Smith, Medical Staff Report to the Eighth Annual Conference of the Guest House Alumni Association, at Lake Orion, Michigan, August 24–26, 1970.

[29] *Prodigal Shepherd*, pp. 219–221. It was this experience that convinced him that alcoholism is an illness.

[30] Bland, *Hibernian Crusade*, p. 250, cites this as an example that Father George Zurcher, who was a strong advocate of enforced legal prohibition, "seems to have grown more extreme in his views."

[31] Cahalan *et al.*, *American Drinking Patterns*, pp. 31f.

open–end question on opinion why some priests leave their ministry.[32] Abstinence from both drink and sex was worded as the dual problem of "Punch and Judy" but there was no indication one led to the other. As Cahalan remarks in the context of marital status, "it cannot be established from the correlational data which comes first, the separation or the heavy drinking."

There is, of course, a vast and symbolic difference between the bachelor and the priest who sacrificially assumes celibacy in the service of others. Aside from the religious and psychological significance of clerical celibacy there is also the sociological support of the so–called priestly fraternity. The concept of some kind of "support mechanism" has developed among Protestant clergy, and is probably even more relevant for the priest who is "on the way" to becoming an excessive drinker or an alcoholic.[33]

AUTHORITY EXERTS PRESSURES

Aside from celibacy is the pervasive experience with the so–called "authority problem" [34] Ordination to the Catholic priesthood of the Latin rite involves not only a commitment to celibacy, but also a special kind of life–long obedience to ecclesiastical superiors not generally demanded of men in other professions. The priest whose heavy drinking is known to religious superiors is likely to "be in trouble" with these authorities, but here again we do not know whether heavy drinking is the cause or the effect of "being in trouble."

All occupational bureaucracies make demands on their employees, including their well–trained and high status personnel, but most do not deal with men who have made a life–long commitment to the organization. Professors can switch to another university, business managers can move to another company, other professionals can find alternative employment. No other system of institutionalized professionalism (except perhaps the academy–trained military) exercises the all–enveloping conditions of work and living that characterizes the Catholic ecclesiastical system.[35] The ultimate alternative for the priest who resists this arrangement is to quit the ministry, an alternative chosen by many priests in the aftermath of the Second Vatican Council.

A fourth element that may be peculiar to the clergyman is his highly flexible work schedule, especially of the parish priest who "often does not have a fixed schedule of duties during the day, but has many

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[32] Joseph H. Fichter, *America's Forgotten Priests* (New York: Harper and Row, 1968) p. 169.

[33] See Gerald Jud, Edgar Mills and Genevieve Burch, *Ex–Pastors: Why Men Leave the Parish Ministry* (Philadelphia: Pilgrim Press, 1970) pp. 123–131.

[34] "The most frequently mentioned problem for priests is not celibacy but authority." Andrew Greeley, *Priests in the United States* (Garden City: Doubleday, 1972) p. 146.

[35] This comparison was noted earlier from the point of view of the training system of religious professionals. Joseph H. Fichter, *Religion as an Occupation* (Notre Dame: University of Notre Dame Press, 1961) p. 88.

different kinds of activities which do not easily fall into an orderly pattern." [36] In a multi–staff urban parish he may be strictly "on call" only one day a week, and during the rest of the week he may have the mobility and privacy that make it easy for him to cover up his drinking. In this way he is similar to the heavy–drinking executive in business corporations who also "has no time clock to punch, no supervisor watching his comings and goings." [37]

Obviously, the clergyman, in spite of the complaint that "you can't make a move without the parishioners knowing it," is not subject to the kind of supervision lower echelon employees have. Indeed, he may have people who "cover up" for him, a sympathetic housekeeper or secretary, fellow priests who are unwilling to delate him to higher superiors, parishioners who want to protect him from scandal; perhaps even the bishop feels that a change of assignment will help the priest to "straighten himself out."

This description of the characteristics of American Catholic clergy is not meant to be an "explanation" of their drinking habits, or of potential alcoholism among priests. It simply provides the setting in which some priests develop a drinking problem and in which the overwhelming majority of priests do not become alcoholics. The publicity in recent years surrounding the question of alcoholic drinking leads to the impression that the incidence of alcoholism is rising in all areas of living, including that of the clergy. Since we have no reliable earlier data with which we can compare contemporary findings these interpretations must remain impressionistic, and are probably false.

MORE THAN SANCTIONS ARE NEEDED

The significant difference over the past quarter–century–dating approximately from the time when Ralph Pfau and Austin Ripley began to have an apostolic impact—is the development of programs of education and prevention of alcoholism, and especially of official policies for therapeutic treatment. From the point of view of rehabilitation a central factor is the determination, especially by ecclesiastical authorities, that the problem drinker in the clergy must be confronted with something more than a punitive sanction.

At the NCCA convention in 1967 the memorialist of Father Pfau looked into the past to say that "all the ecclesiastical penalties hurled by the best–intentioned bishops against the best–intentioned priests in the world could not effect a cure. In fact grief over such penalties could induce despondency and despair that might lead to heavier alcoholic

[36] *Ibid.*, p. 159.
[37] Editorial, "The Alcoholic Executive," *Fortune*, January, 1960, pp. 99–101, 167.

indulgence, a worse destructiveness." [38] In other words, penalties and the threat of penalties appeared ineffective in changing the drinking habits of alcoholics. There was also the maxim, perhaps still believed by some, that there was no use trying to rehabilitate an excessive drinker until he came to the self–realization that he could not handle his liquor.

In other occupational systems the alcoholic employee has been forced to undergo "crisis precipitation," that is, he was induced to make a choice between entering a therapy program or losing his job. The individual is brought face to face with a critical choice, but this crisis must be precipitated with a certain finesse. After all, as Harrison Trice remarks, "alcoholics are so notably thin–skinned, whatever their level of employment, that it is advisable to handle all of them as if they were executives." [39]

GIVE UP ONE OR THE OTHER

It is a momentous suggestion that a priest should be confronted with the choice of giving up either his drinking or his ministry, and even the most authoritarian religious superior is reluctant to force a confrontation of such seriousness. Yet this is, in effect, the kind of advice now found in the clergy policies for treatment and rehabilitation. In ecclesiastical circles, however, this approach is often called "benevolent coercion" or among the alcoholic priests themselves, "tough love." Bishop McCarthy thought this special understanding should be brought from the leaders of NCCA to the bishops and superiors: "the understanding that tough love is required, that benevolent coercion is required at times." [40] It is urged also that this "toughness" should be exercised by one priest to another:

> At times it requires courage, even heroic courage, to confront a brother priest and tell him that he is destroying himself and others. It is the kind of love that is willing to run the risk of sacrificing even a long–standing friendship, rather than stand by mutely and timidly while you watch this friend go down the drain.[41]

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[38] Raymond Atkins, "In Memoriam: Father Ralph Sylvester Pfau," *The Blue Book*, Vol. XIX, 1967, p. xiii. This is reminiscent of the words of a socially aware pastor, David Phelan, who advised the delegates to the 1896 Total Abstinence convention that "the greatest enemy we have to contend with today is not the appetite for liquor but the habit of despair. There are drunkards today because they are desperate. They do not see any way out of their misery, so they take to the glass as their last and final resort." Quoted in Bland, *Hibernian Crusade*, p. 209.

[39] Quoted in Herryman Maurer, "The Beginning of Wisdom about Alcoholism," *Fortune*, May, 1968, pp. 176–178, 211–215.

[40] Edward McCarthy at Closing Plenary Session, *The Blue Book*, Vol, XXVI, 1974, p. 197.

[41] Edward Murray, "Priests' Recovery Program" (Boston) *The Blue Book*, Vol, XXV, 1973, p. 173.

FACING LOSS OF CONTROL: THE KEY TO COUNSELING AN ALCOHOLIC

Duane P. Mehl, Ph.D

I am a clergyman, and I am a chemically dependent person. I have had addictive experience both with alcohol and such sedative drugs as barbiturates and minor tranquilizers. I have been free from drugs for a little more than five years. During the last four years I have worked professionally in the chemical dependencies field.

In other words, I have put in my time on both sides of the fence. And I believe my addictive experience gives me some advantage when discussing alcoholism and related dependencies. Though non–alcoholics working in the field of drug abuse don't want to admit their difficulties in identifying and empathizing with alcoholics, these professionals, in my experience, often miss that key experience through which addiction must ultimately be probed and treated: *Loss of control.* First of all, therefore, I want to describe the nature of that experience, and secondly I want to suggest how clergy may use the experience to assist the chemically dependent toward recovery.

John Keller, Administrative Director of the Rehabilitation Center, Lutheran General Hospital, Park Ridge, Illinois, describes the experience in this way:

> The alcoholic initially loses control over the amount that he drinks. He can't predict what will happen after he takes the first drink. . . . As the alcoholism progresses he will also lose control over the time when he drinks and thus drink when he doesn't plan to drink. He reaches the point where he literally can't keep from drinking or control the amount he drinks.[1]

The addict really needs no one to define or explain the experience to him. Addicts simply discover, usually to their horror, that they have fallen victim to the drugs they use. A substance they once controlled now controls them and their lives. If they once had healthy dependencies on other human beings, social and community institutions, or God, now they depend entirely on their mood–altering chemicals.

[1] John Keller, *Ministering to the Alcoholic* (Minneapolis: Augsburg Press, 1966), p. 27.

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THE ROAD TO LOSS OF CONTROL

The typical alcoholic or dependent on depressant drugs moves toward loss of control rather slowly. I want to emphasize that point. Loss of control is not generally a dramatic conversion experience in reverse. One day I'm in control; that night, like Count Dracula, I'm out of control.

For instance: After I ruptured a disk in 1962, at the age of 31, I was placed, for the first time in my life, on a sedative program for sleep and tranquilization. I only felt the need to increase my intake of seconal for sleeping purposes after six months. I asked for more pills and got them. After a year I went to a second doctor, complained about insomnia, and got more seconal and more Librium. After one year, however, I used seconal only at night and Librium during the day. I obtained a fairly high plateau of euphoria each day—though without risk of detection and with a clear conscience since I needed pills for continuing pain.

When I moved into my third year of regular consumption of sedatives and tranquilizers, and after the pain in my lower back and legs had subsided, I began using pills more erratically and in greater quantities to achieve higher plateaus of intoxication. It was not until the *fourth year*, however, that I ever used a hypnotic type drug during the day. When I began to use sedatives occasionally during the day, I believe I crossed the line from control to loss of control—though I was scarcely aware of my "loss." I gradually became aware of this as my "plateaus" became higher and I found it impossible to function with full productivity and objectivity. I was balmy a great deal of the time—though most people didn't realize I was taking drugs and thought, at worst, I was depressed. I made no effort to persuade them otherwise.

Eventually, when my doctors withdrew my drugs, I switched to alcohol to obtain sedative effects similar to those produced by the prescription drugs. I discovered that I had developed a high tolerance for alcohol through the intake of sedatives. However, I maintained a basic plateau pattern also in my drinking—though my plateau was out of the "normal" range.

I emphasize this point deliberately. Though the vast majority of alcoholics in this country lose control of their drug (in the sense of Keller's description) and consume erratically in unpredictable quantities, a percentage of dependent persons consume irresponsibly by becoming too balmy each day. That percentage includes especially, in my own counseling experiences, those persons abusing hypnotic or tranquilizing drugs. They include, therefore, a high percentage of women, since women use more depressant medications than men in this

country.[2] The percentage also includes business and professional people, as well as so–called "working" people (especially beer drinkers), who consume large quantities of alcohol for lunch, before dinner, and before bedtime, and yet stop this side of total disorientation. Such persons, like myself, are just as alcoholic or chemically dependent as those who drink themselves under the table every time they take the cork out of the bottle.

BEHAVIORAL CHANGES

Behavioral changes accompanying loss of control over mood–altering drugs are pathological, or, if you will, deeply evil in the most profoundly moral and metaphysical senses of the word. The addict becomes phenomenally sick, physically, emotionally and spiritually. Every addict knows this, no matter how intense or complicated the issue becomes among the researchers in the field.

I want to emphasize with considerable intensity the "spiritual" nature of the illness. Alcoholics Anonymous has not called the illness "spiritual" for so many years simply out of commitment to some outmoded world perspective or religious point of view. Rather, sick alcoholics and recovering alcoholics discover, in the process of alcoholic deterioration, a remarkable collapse of moral sensitivity and judgment, and an equally remarkable collapse in healthy relationships with other persons and with God. The drug, in fact, becomes God to the alcoholic or similar addict. The illness factor in addiction could not be expressed more succinctly.

After losing control over consumption of alcohol or drugs, the addict begins a natural downward development into spectacularly unnatural behavior. A.A.'s description of the power of alcohol in this phase may seem florid, but it is accurate: "Remember we deal with alcohol—cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power—that One is God. May you find Him now!" [3]

The alcoholic, plunging downward, however, does not typically turn with any seriousness to God. He turns to an alibi system to explain his increasingly bizarre behavior. He must explain his actions to himself, and to the important people in his life—especially his wife, children, or parents. (For the sake of grammatical efficiency, I am referring to the alcoholic in the masculine gender. I do not wish, however, to be chauvinistic in reverse. Female alcoholics exist in the millions, and in all probability, with feminine liberation, are increasing in number.)

As we look for alibis, we discover that we drink because we are tense, depressed, or both. We don't like our jobs, our supervisor, our

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[2] Edward M. Brecher and the Editors of *Consumer Reports*, eds., *Licit & Illicit Drugs* (Boston: Little, Brown and Company, 1972), pp. 478–479.

[3] *Alcoholics Anonymous* (New York: Alcoholics Anonymous World Services, Inc., 1955), p. 55.

superior officer, our fellow employees, nor do we like Henry Kissinger or Gerald Ford or the Arabs, or Jimmy Carter, or the Pittsburgh Steelers. Most certainly we discover we can't stand our wives, or our children, our dog or our cat. Also, we can't stand the weather which is either too hot or too cold, too dry or too humid. We have nothing interesting to do; life is a bore. We are too poor or too rich; inflation and taxes are killing us. So we drink or pop pills, or if we're younger we may shoot speed (amphetamines), use cocaine (usually with alcohol), or some other downer. Speed exhilarates a person rapidly, especially when injected, and seems to make "troubles" disappear even more quickly than alcohol or barbiturates.

When we drink or pop pills, we also discover well–springs of grandiosity and fantasy we had not possessed. Though we may have virtually lost our jobs and our families, blown our budget to pieces, and reduced our general productivity to near zero, we confidently fantasize that we will get organized next week, or *even tomorrow.* Tomorrow we'll stop. We'll write the great American novel, or make a million dollars, or get our job straightened out and our supervisor off our back—indeed, we'll *have* his job! We'll finish two years of neglected household repairs, and keep our wife out of the divorce court.

I know an alcoholic, a former patient of mine, who decided one winter afternoon to repair the engine of his car, though he knew nothing about engine repair. In a "half–snuckered" state of mind, however, he believed himself capable of anything. He could leap tall buildings with a single bound. Why couldn't he repair his car? So he went to his garage and began to take various engine parts out of his car. Since it was cold in the garage, he decided to place the parts on newspaper on the living room carpet. He continued this for about an hour and then fell asleep, due to alcoholic fatigue and the unaccustomed exertion.

His wife arrived home to find him sleeping like Little Boy Blue on the living room floor, surrounded by the engine of their car. When he awoke to sober reality, he had to hire a mechanic to put the engine back together. How he put his marriage back together, I don't quite remember.

That is addictive grandiosity—a reaction to the guilt and loss of self–respect experienced by the drinking alcoholic every day. He attempts, in those grandiose moments, to cover up the dismal reality of it all. He wants to say to the world: "Everything's cool," though the world falls to pieces on his head.

The plummeting alcoholic, now totally out of control, becomes both aggressive and withdrawn, though far more withdrawn on the average than aggressive. He may drink at his neighborhood tavern, but generally by himself. When he discovers that few at the bar welcome

him any longer, he may challenge them to fight, and is usually beaten and thrown out. Eventually, the bartender denies his entry to the bar and, more depressed than ever, the alcoholic moves on to another bar.

At home he finds a quiet place to drink. He avoids his family as much as possible, arrives last for dinner and leaves first. He spends as much time as possible in his "workroom" or his "study" where he's hidden bottles in concealed hideaways.

Occasionally, he becomes terrifyingly aggressive toward wife, children, or parents. The alcoholic or barbiturate addict is especially dangerous after very heavy consumption of drugs in a home or party atmosphere where the spouse and other family members remain sober. The addict expects criticism from sober family members so he reacts with violence to prevent it. The family member may end up with a black eye, loose teeth, or even a fractured arm or skull.

The following morning, the alcoholic remembers little or nothing about the episode because of "blackout"—memory loss. But the broken face or arm of his loved one reminds him, especially his conscience, of what he has done. All of this "naturally" drives him to the "eye–opener," the first drink of the day to prevent shakes and gastric upheavals due not only to a damaged nervous system but to extreme guilt. The first drink or pill upon awakening, in other words, is just one more predictable development following loss of control over a mood–altering drug.

In the midst of the downward plunge, job performance naturally falls off. Though the addict usually struggles desperately to maintain his balance on the job, or on duty, he will fail to perform as well as before. He becomes a risk to his company, his unit, his fellow employees, his fellow human beings. He knows it, and slowly others come to know it also.

Naturally, the addict's family follows him into a "neurotic" tailspin. Most family members, especially wives, first try to deny the addiction just as the addict tries to deny it. The family members become depressed as the addict becomes depressed. Wives in particular tend to blame themselves for their husband's incredible behavior, and their husbands are only too happy to agree.

ENTER THE COUNSELOR

Typically, the counselor enters the scene at approximately this point. The situation is largely out of control. The addict is out of control in the consumption of his drug. The family is out of control with depression, anxiety, denial, confusion. And job performance is out of control.

I want to emphasize, however, that not all alcoholics or drug addicts reach this level before seeking help. I didn't. Many alcoholics, seek help in programmed treatment long before they reach a low level of

deterioration. Some are able to exercise sufficient self–control over alcohol or other drugs to prevent loss of jobs or family. Because of successful efforts in educating the American people to the realities of alcoholism as a treatable illness, more and more addicted persons are looking for help earlier in the development of their illness.

CONTROLLED DRINKING?

I raise the point because of the present furor over the possibilities of "controlled drinking" for the chronic alcoholic, possibilities publicized in a peculiarly spectacular news release from the Rand Corporation in July, 1976. Ironically, Rand researchers discovered what alcoholics and professionals in the field have known for years. Some alcoholics do exercise considerable control over their drinking. Some alcoholics remain "plateau" drinkers throughout their lives. They never lose control in the sense of Keller's definition of loss of control. Their plateau, however, is a high plateau, a level of intoxication which makes responsible living difficult and perhaps impossible.

Rand discovered, predictably, that some alcoholics (about 25 percent), when returning to alcohol after treatment, are able to reduce and control their consumption over periods of time (in some cases for years and, if "plateau" types, perhaps for life). Typically, however, we know that such "controlled drinkers" will lose control eventually due to tolerance for alcohol, and physical and emotional problems (often simply the aging process).

A SPIRITUAL ILLNESS

To complicate this matter further, a large body of researchers in this country today seem committed to proving that alcoholics may be able to return to controlled drinking through various therapeutic programs, usually involving aversion techniques or more probably group therapy dynamics.[4] My personal opinion, widely shared by others in the treatment field, is that the majority of such researchers pursue this goal, at least in part, out of personal aversion toward A.A. and hospital programs dependent upon the A.A. program. I believe professional researchers, especially clinical psychologists, have difficulty coming to terms with the "spiritual dimensions" of the A.A. program, and *consequently* with the abstinence factor involved in any A.A. method of counsel or treatment.

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[4] Six articles on or pertaining to the subject of controlled drinking as an option to abstinence and programs of treatment involving abstinence have appeared in the *Journal of Studies on Alcohol* since January, 1976. M. Tomsonic, "Group Therapy and Changes in the Self–Concept of the Alcoholic," 37 (January, 1976), 53–57; D.J. Feeney, Jr., P. Granger, "Alcoholics View Group Therapy; Process and Goals," 37 (May, 1976), 611–618; A.F. Fontane, B.N. Bowds, M.H. Bethel, "A.A. and Group Therapy for Alcoholics: an Application of the World Hypothesis Scale," 37 (May, 1976), 675–682; R.C. Popham, W. Schmidt, "Some Factors Affecting the Likelihood of Moderate Drinking by Treated Alcoholics," 37 (July, 1976), 868–882; O Pomerleau, M. Pertschuk, J. Stinnett, "A Critical Examination of Some Current Assumptions in the Treatment of Alcoholism," 37 (July, 1976), 849–867; J.J. Hinrichsen, "Locus of Control Among Alcoholics; Some Empirical and Conceptual Issues," 37 (July, 1976), 908–916.

The necessity for abstinence from alcohol is linked historically by A.A. with the belief that alcoholism is a physical, emotional, and spiritual *illness* over which the alcoholic is powerless. A.A. directly supplies in Step Two a higher Power, or God, to supplant powerlessness experienced by the alcoholic. The alcoholic cannot "turn" his life over to "God as he understands Him," however, unless he is freed from alcohol to do so.

Because A.A. has historically linked the need for abstinence with the concept of alcoholism as a complex illness, a part of the research community in this field has chosen to question the disease concept of alcoholism. The strategem may be simply summarized: If alcoholism is not an illness, physical, emotional, and spiritual, then the troubled person (no longer, strictly speaking, an alcoholic at all) may return to normal drinking after he has discovered, through group therapy, those factors (usually a poorly developed ego caused by inadequate parents) which induced him to drink too heavily in the first place. When he has discovered his reasons for drinking—why he made the decision, as it were, to become a heavy drinker—then he will cease being a heavy drinker and return to controlled consumption.

For example, in July 1976, Pomerleau, Pertschuk, and Stinnett, in an article titled "A Critical Examination of Some Current Assumptions in the Treatment of Alcoholism" in the *Journal of Studies on Alcohol*, questioned the advisibility of promoting abstinence as a factor in the treatment of most alcoholics. The writers supply sketchy statistical data to support the possibility of treatment approaches to controlled drinking for the alcoholic (or "problem drinker") and reveal at the end of their article the basic reason for their interest in the subject:

> The traditional approach to treatment has been designed for the problem drinker who has hit "bottom" and is not willing to "surrender to therapy." Thus a possible explanation for the difficulty of getting alcoholics into therapy—especially in the early stages of the disorder—may come from the unwillingness to enter a treatment modality which requires abstinence.[5]

Please note the inverted commas around the words "bottom" and "surrender to therapy," and the critical implications introduced by the typology. The bottom concept, or collapse of the alcoholic's alibi system, and the surrender concept—surrender both to the reality of alcoholism and to the reality of need for a Power higher than self for recovery—are core A.A. concepts and have been adapted as core concepts in the most successful treatment "modalities" in this country, as I'm sure the authors know full well.

Note also, that these concepts are fundamentally religious in

[5] O. Pomerleau, M. Pertschuk, J. Stinnett, "A Critical Examination of Some Current Assumptions in the Treatment of Alcoholism," *Journal of Studies on Alcohol*, 37 (July, 1976), p. 863.

nature and require, if you will, a virtually pastoral approach in counseling, whether from a pastor, an alcoholism counselor, or a doctor. Now religious concepts are difficult to grasp in a secular culture, especially by those trained to offer care and counsel by means of secular methods. These concepts are particularly difficult to put into practice, because they require surrender of the needy self to a saving God. Obviously, millions of alcoholic Americans resist such surrender. No one is ever prepared for such an experience. But powerlessness over alcohol or a similar drug simply forces the necessity upon the addict whether he likes it or not.

Personally, I know how difficult the admission of powerlessness is and how brutally complicated the surrender of self to God can become—even when the need seems obvious.[6] I remain convinced, however, on the basis of my own experience and my experiences with hundreds of other alcoholics, that I was helplessly ill with addiction, physically, emotionally and spiritually, that I had to admit to that helplessness, and that I needed help from powers and a Power higher than myself. I am, furthermore, convinced on the basis of my previous loss of control over drugs, and through my contact with recovering alcoholics, that I must remain free from alcohol and similar drugs in order to prevent a return to abusive and compulsive consumption of mood–altering chemicals. Once a person has learned in the depths of his soul the effects of a mood–altering (especially an euphoria–inducing) drug, he never forgets those effects. No matter how long he may control his consumption upon return to those drugs after abstinence, he will eventually, because of false self–confidence or stress, begin to abuse and lose control over his drugs once again.

I have yet to meet one doctor, one alcoholism counselor, one alcoholism program director, one nurse, one pastor, one chaplain, one alcoholic, who has successfully helped an addicted person back to controlled use of his drug. I have met and know literally hundreds of alcoholics who have tried controlled drinking and have failed. Whether abstinence, admission of powerlessness, or reliance on a Power higher than self is attractive to alcoholics or not, those factors remain vital in all successful programs for treatment of addiction. This means, undoubtedly, that the majority of alcoholics in this country will not seek help—because the helping process puts so much demand on the alcoholic. But until an actual program—not merely a research project based on questionable samplings of those supplying versions of their own "controlled" drinking—for the cultivation of controlled drinking appears, we must remain committed to abstinence, to the disease concept, and to spiritual dynamics as necessary dimensions in a productive recovery process.

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[6] Duane Mehl, *No More for the Road* (Minneapolis: Augsburg Publishing House, 1976), pp. 43–60.

CONFRONTING LOSS OF CONTROL

We must attempt to utilize the loss of control experience in the addict's favor. In effect, we must not allow him to waste his mistakes. We have to confront him, empathetically, with the reality of his loss of control.

I said empathetically. That's why I believe the alcoholic counselor has the edge in counseling the alcoholic—especially if the alcoholic counselor has been sober for some years and has had training in confrontive counseling methods. The non–alcoholic counselor, however, can build bridges between himself and the alcoholic. He may, even early in the counseling process, let the client know that he doesn't see himself invulnerable to addiction and doesn't look on the alcoholic as some strange creature. The counselor admits he has problems of his own.

In theological terms, the counselor lives under God's judgment and feels it, as does the alcoholic. Perhaps because pastors know and feel this reality greater than physicians, or clinical psychologists, they make better counselors for chemically dependent persons than those of other caring professions. Religious sensitivity and theological training do make a difference—a considerable one.

Don't underestimate your own experience with addiction. If you smoke cigarettes or consume food excessively, you are an addict. You have much to share with, and perhaps something to gain from sober alcoholics, especially from those who don't smoke. Nicotine is currently considered the most addictive substance known to man. In the book *Licit and Illicit Drugs*, Dr. A. M. Hamilton Russel of the Addiction Research Unit of the Institute of Psychiatry, London, reports: "It requires no more than three or four casual cigarettes during adolescence . . . virtually to ensure that a person will eventually become a regular dependent smoker." [7] Both tolerance to and need for the drug build up so swiftly that the vast majority of casual smokers smoke most uncasually in a matter of weeks. Furthermore, nicotine must be consumed by the addict more frequently than any other known mood–altering drug. The average nicotine addict does well if he limits his intake of nicotine to one dose per hour, day after day, without stop. If you smoke regularly, you are just as surely an addict as any alcoholic who drinks out of control. You have much in common with him.

No matter how empathic we become toward the alcoholic client, however, we must ultimately confront him with the reality of loss of control over alcohol and/or similar mood–altering chemicals. To do this, we listen carefully to the alcoholic and accumulate data to show him he is an alcoholic. Though the alcoholic may insist that he drinks only a

[7] Edward M. Brecher and the Editors of Consumer Reports, eds. *Licit & Illicit Drugs* (Boston: Little, Brown and Company, 1972), p. 224.

"couple of beers" a day (the classic litany among alcoholics), the typical alcoholic in conversation with a pastoral counselor will reveal the following in an initial counseling session:

—He drinks in a recognizable pattern to relieve tension (after work, before bed, etc.)

—He experiences some preoccupation or guilt feelings over his pattern of drinking.

—His wife or family members have told him he drinks too much or that something is wrong.

—He drinks more ("gulps") than normal drinkers, or he "sneaks" drinks at home or during parties when others are not looking. (Sometimes he boasts that he can hold his liquor better than others.) The drinker, in other words, reveals tolerance for his drug.

—He experiences some blackouts or memory losses when awakening after heavy drinking. Typically, the alcoholic admits to this experience hesitantly when questioned in an empathic manner. (For example, the counselor may say, "Many alcoholics and problem drinkers experience loss of memory when awakening after a heavy night of drinking. I can remember having an experience like that myself when I was in college. Do you sometimes have similar experiences?")

—He experiences difficulties with friends and certainly with family members because of his drinking. (Again, the honest answer usually follows a judicious question: "Has your wife ever complained about your drinking?" The word "complained" allows the alcoholic to focus on his wife's behavior while exposing his own. Later you can tell him that typical wives do not complain about their husband's normal drinking patterns.)

Always keep the focus in counseling on the client's *drinking*. You may ask: "Has your supervisor or superior officer cautioned you about your drinking?" Again, allow the client to complain about his supervisor or superior officer. Nonetheless, you have to keep the focus on alcohol. In the process of talking about his supervisor or superior officer, the alcoholic will inevitably talk about his drinking problems on the job.

Having accumulated the above data, you are in a position to make a diagnosis, at the very least, of chronic alcoholism in the middle or loss of control phase. As counselor you are then in a position, if you have established an empathic relationship with the client, to suggest a diagnostic test of the type supplied by A.A. (prepared by Johns Hopkins University Hospital).

If the client has taken a diagnostic test, the counselor may simply tell him that the evidence which the alcoholic himself has supplied suggests overwhelmingly that he is chronically alcoholic and needs special help for recovery. Since the alcoholic has lost control of his

drinking, he cannot expect to return to health and normality without help. He must develop a life style centered on persons and activities which literally displace the drugs in his life. The counselor then must supply the client with specific A.A. groups, A.A. members, physicians or hospital treatment programs which can help him *now*. Be precise and insistent in referral.

When the client resists the diagnosis, the counselor must insist all the more firmly that he needs a *community* of recovering alcoholics where he may *learn* more about his addiction and the possibility of a recovery process. A.A. groups and hospital programs specializing in the treatment of addictive disorders provide precisely those communities for the addict. No alcoholic—even those deeply resistant to the admission of alcoholism—lacks resources for recovery in this country. Satisfied and even plausibly serene, abstaining alcoholics available for service and counsel without charge exist in large numbers everywhere—not only in large urban communities but in rural areas as well. Hospital programs, modeled on the A.A. program, exist everywhere in America. A trip to a Central Service agency of A.A., or to the office of the local National Council on Alcoholism, will provide any counselor with a wealth of resources available in his community. We can no longer pretend that we have no place to turn for assistance even with *resisting* alcoholics or similar addicts. The burden of potential recovery lies on caring professionals. We must learn to use the growing number of resources available to us.

THE GOD STEPS

After a pastoral counselor has referred an addicted person to an A.A. group or to a hospital program, he still has the option—based primarily on the depth of his understanding of alcoholism and of the A.A. program—to help the addicted person work the so–called "God steps" of the A.A. program (God or a higher Power is mentioned fully six times in the Twelve Steps). Step Two of the A.A. program reads: "[We] came to believe that a Power greater than ourselves could restore us to sanity." Step Three reads: "[We] made a decision to turn our will and our lives over to the care of God as we understood Him." As previously mentioned, Step Two provides a "Power" in response to the human powerlessness described in Step One. The progression in language is obviously intentional and is descriptive of an experience in recovery. The addict, after admitting powerlessness over alcohol, must find a Power greater than self to counteract powerlessness over drugs. On any level, theological or plainly empirical (if there is a difference), the progression is based on common sense.

Most recovering alcoholics in A.A. programs attempt to form a relationship with God. And most chemically dependent people have

difficulties in establishing such relationships. Since my responsibility in the hospital where I work is to help alcoholics in this area, I am particularly sensitive to the problems typical addicts face. I have discovered the following:

1) Almost everyone in a hospital treatment program has some feeling for a power or force sustaining the universe and life. The majority, however, have difficulty personalizing that power. In clinical terms, they have difficulty objectifying the Power and therefore tend to separate their emotional experience of loss of control from their intellectual concept of a higher power.

2) The majority of those in a treatment center have difficulty relating past religious training and experiences with the Power they presently need to combat loss of control over drugs. A.A. has been cannily effective by labeling its program "spiritual" rather than religious, because "religious" suggests repressive denominational connections.

3) The vast majority of those in treatment centers have difficulty, no matter what their denominational background (except Pentecostal), thinking of God as Jesus Christ, even though they may say Jesus Christ is God. American people tend to think of God as providence or as a judge rather than as incarnate in Jesus Christ (or nature) as regenerator or forgiver. American religious sensitivity is heavily docetic and gnostic. Ironically, Jesus Christ, I believe, is rendered in popular consciousness more docetic than God himself.

As a pastoral counselor you may, however, as I have suggested in my own book, present Christ as a model reflecting the addict's experience both as a sufferer and as one who rises from suffering.[8] If the client has capacities for thinking of Christ as both human and divine, he may identify with Christ and find in him a source of divine forgiveness and power for the future.

If you can help the recovering addict personalize God in one fashion or another, you will greatly increase his possibilities of recovery through the A.A. program. I have been able to provide this kind of assistance consistently in one–to–one counseling situations. People in groups resist Christological language. When alone, facing problems over which they have no control, they may find themselves identifying with Christ almost effortlessly.

If the addict is able to find in Christ a resource for recovery, then the counselor may recommend him to a Christian congregation gathered around Word and Sacrament—that is, gathered consistently around Powers higher than self. Consistent with your own denominational

[8] Duane Mehl, *No More for the Road* (Minneapolis: Augsburg Publishing House, 1976), pp. 123–132.

traditions, you may recommend the Holy Communion, Mass or Eucharist, Penance or Confession, the simple gathering of loving Christian or Jewish people as sources of *divine* and human help for the future.

Even when the addict is unable to personalize God, the pastoral counselor may help him immeasurably by teaching him literally how to pray, how to size up each day and bring failures to God (or "power out there") for forgiveness, and how to express gratitude to God for success. A.A. has a slogan, "Let go, let God." Through it A.A. means to say, "Let God be God." Let God have the failures as well as the successes. Let God have the day past and let God have the day present. Don't fight the day all by yourself. "Take it easy." You can't control or manage the day or even the hours or the minutes. You can only act responsibly, as best as you can, and let God have the rest. The buck stops with God.

The alcoholic who recovers with the greatest satisfaction and serenity recovers with exactly this attitude toward daily life. He quite literally learns, in fact, the mood of Matthew 6: "Let the day's own trouble be sufficient for the day."

In my personal opinion, the pastoral counselor is best equipped to embody this truth for the recovering alcoholic. For this reason I strongly recommend that the chaplain or pastor assist persons working the A.A. program in meetings or in hospital treatment. Addicts in A.A. are usually no more familiar or at ease with religious experience than the proverbial man or woman on the streets. Hopefully we in the pastoral profession are.

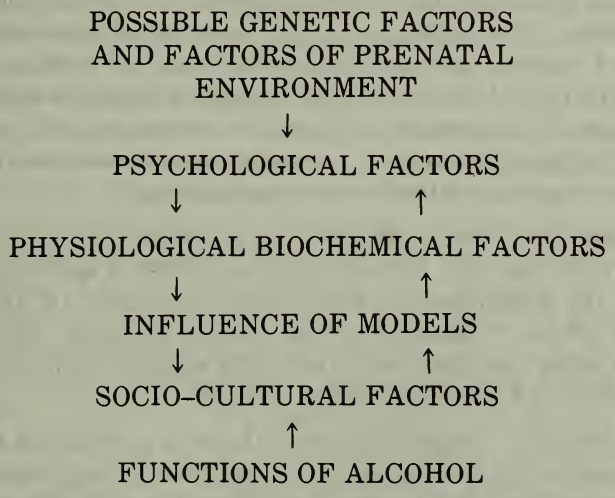
If so, we must share our experiences with our addicted brothers and sisters who so desperately need our help for escape from a fate more damnable than death itself. We dare not pass the addict by on the other side—or neglect him when he is, more predictably, in our own backyard.

A SURVEY OF JEWISH DRINKING PATTERNS

Chaplain (MAJ) Thomas M. Hill

Alcoholism is being studied by research scientists with every conceivable background and subject orientation. The dual concerns of understanding the etiology and developing effective treatment methods have interested professionals from this wide diversity because of a growing awareness about the interrelated effects of problem drinking and numerous other problems evident in today's social environments.

Few absolute conclusions have been reached to date concerning etiology. There is, however, a general understanding that causality is probably a complicated mixture of circumstances that displays a similarly complicated degree of variability from one individual to another, or one group to another.



This interaction is presented by Morris Chafetz and Harold Demone.[1]

A study of the Chafetz and Demone factors reveals that there are apparent differences in drinking patterns between certain groups of

[1] Morris E. Chafetz and Harold W. Demone, Jr., *Alcoholism and Society* (New York: Oxford University Press, 1962), p. 29.

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individuals. Some of these patterns are less variable than others. The Jews are a case in point.

PURPOSE OF THIS ARTICLE

It is my hope to discover something of value in studying the low percentage of Jewish drinking problems that can be applied in programs of education and treatment for the benefit of non-Jews. This will be pursued by a study of two of the Chafetz and Demone factors: (1) Socio–Cultural Factors; and (2) the Influence of Models. In addition, because of the particular significance of the historical perspective, a brief survey of Biblical and historical references will serve as a foundation for the study.

BIBLICAL AND HISTORICAL PERSPECTIVE

Many instances in the Old Testament reveal abuse of alcohol in both social and individual contexts.[2] History, however, had its own minimizing influence. It is suggested, for example, that during the 200 years following the return from the first (Babylonian) exile, drunkenness all but disappeared from the people of Yahweh as they fought to banish the Canaanite gods and their orgiastic, drunken festivals. With the success of this effort, the Hebrew scripture was formally adopted as the constitution of the nation, synagogues were established as places of learning and worship, and the ritual use of wine was fixed as a part of that worship. There is some evidence that a few instances of abuse and lingering fear of drunkenness survived for several hundred years, but by the Middle Ages in Europe ". . . neither drunkenness nor the fear of it any longer survived in the Jewish communities." [3]

During the Diaspora, families and communities of Jews grew in number. Their status in various countries differed according to the attitude of the government and the general populace. In Alexandria, there was official "toleration" of the Jewish presence, but in most places—including Alexandria—the exclusive religion of the Jews stimulated prejudice and antipathy among others.[4]

As seems to happen whenever there is a prejudice toward a minority, oppression became central to the lifestyle and experience of Jewish communities. This tended to reinforce the solidarity of Jewishness throughout the Roman world. A national consciousness, based on their religion, emerged. Early practices and rituals grew in uniformity to the extent that being Jewish meant accepting an ethnic as well as religious value system.[5] This resulted in an increased ". . . demand for

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[2] See Irving W. Raymond, *The Teaching of the Early Church on the Use of Wine and Strong Drink* (New York: AMS Press, 1970), p. 26.

[3] M. Keller, "The Great Jewish Drink Mystery," *Brit J Addict*, LXIV (1970), pp. 287–296 (CAAAL Abst. #13802).

[4] Raymond, *Teaching of Early Church*, p. 16.

[5] *Ibid.*

a rationally controlled impulse life subordinated to higher ends." [6]

We find a still more meaningful insight into the attitudes of the Jewish people concerning alcoholic beverages in their philosophical approach to life. Jewish ethical teachings center in the concept that "Nature is a work of God created for the purpose of aiding man in his quest for holiness, the true vocation and ideal for man. Wine as a part of this beneficial creation is therefore necessarily good and hence can be used legitimately by man." [7]

> The numerous allusions to the vine and wine in the Old Testament furnish an admirable basis for the study of its estimation among the people at large. . . . Wine is a gift of God and as such is used as a symbol to denote any gift of God to man. . . . An abundance of wine was regarded as a sign of God's special blessing and an extraordinary crop was viewed as a token of the approach of Messiah. . . . This favorable view, however, is balanced by an unfavorable estimate. . . . wine is practically used as a synonym for drunkenness, and the terms of disapprobation in which drunkenness is mentioned apply equally for wine. The reason for the presence of these two conflicting opinions on the nature of wine need occasion no such anxiety as some writers have experienced. The answer is simple. *The consequences of wine drinking follow its use and not its nature.*[8]

This perceptive insight by Irving Raymond reveals the essence of Jewish philosophy concerning beverage alcohol (particularly wine), and the concept of "rational control" which permeates so much of Jewish life. This concept of "rational control" emphasizes the strong value of education, deep thought, and moderation—the latter directly influencing patterns of alcohol use. To use wine excessively would, for the Jew, constitute a "personal affront to his God." [9] This is because in using wine excessively, "rational control" is dissipated and those things which can result—dimmed conscience, weakened will and intellect, increased forgetfulness, loss of understanding, and inability to deal with surroundings—are considered abuses of the gift of God. Such abuse constituted a deadening of the spiritual life for sure. As well, there were practical, non-spiritual implications for Jews in alien societies who lost the capacity to deal with their surroundings.[10] Resultingly, there is a very realistic fear that the loss continued to exist in Jewish communities through the pogroms of Europe even to the problems of Jewish communities in other places today.

Traditionally, two well known Jewish communities practiced ab-

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[6] Isidor Thorner, "Ascetic Protestantism and Alcoholism," *Psychiatry*, XVI (1953), pp. 167–176 (CAAAL Abst. #6736).

[7] Raymond, *Teaching of Early Church*, p. 49.

[8] *Ibid.*, pp. 24–25 (emphasis added by author).

[9] *Ibid.*, p. 49.

[10] *Ibid.*, p. 27.

stinence: Nazirites and Rechabites. They not only refrained from drinking wine, but from eating any product of the vine.

> One reason for this was that the wine was the symbol of a settled life and culture, of towns, cities, and earthly securities. The Nazirites and Rechabites were bearing witness to 'the old days' when the people of God were wanderers in the wilderness, pilgrims on earth with no permanent abode. They were bearing witness to total dependence upon God rather than to dependence upon security derived from the amassing of wealth, the development of real estate holdings, or the inheritance of family property.[11]

In addition, High Priests were encouraged to abstain, except from the ritual use of alcohol, because strong drink might hinder the proper execution of their office.[12]

According to Jewish history, then, wine and fruits of the vine are "gifts from God." Coupled with this is the emphasis on "rational control." Finally, "ritual use" of wine, a central focus for Jewish worship in home and synagogue, relates the drinking of wine to that which is sacred. The use of wine in the Old Testament included various sacrifices, religious festivals and funerals, sacred libations at the temples, and offerings of the firstfruits as part of the tithe. In all these instances, wine was used with respect and in moderation. When wine was offered in sacrificial observance, it was always presented with something else (*i.e.*, minerals and oils). All were regarded as gifts from God. It was a sign of homage to God, of thanksgiving and prayer. Even today the three major drinking occasions of the Jewish people are: (1) rites of passage (circumcision, Bar Mitzvah, and marriage); (2) the Sabbath (centered in the family and all its warmth); and (3) holidays and festivals (*e.g.*, Rosh Hashanah, Yom Kippur, Chanukah, Purim, and Passover).[13]

Since alcohol releases tension, and since Jewish people have experienced so much tension in persecution and discrimination, "The low rate of Jewish drinking problems becomes all the more striking when one considers the stresses that Jews are apt to experience . . ." [14] At least, a modern Gentile mind would tend to ponder that issue while momentarily considering this phenomenon from perspectives other than religious.

A SOCIO-CULTURAL PERSPECTIVE FOR THE 20TH CENTURY

Charles R. Snyder has contributed more to the research of Jewish drinking patterns than any other single individual. In the final

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[11] Wayne E. Oates, *Alcohol—In and Out of the Church* (Nashville: Broadman Press, 1966), p. 3.

[12] Raymond, *Teaching of Early Church*, pp. 30–31.

[13] Chafetz and Demone, *Alcoholism and Society*, p. 85.

[14] Rubert Wilkinson, *The Prevention of Drinking Problems* (New York: University Press, 1970), p. 199.

chapter of his major book, *Alcohol and the Jews*, he indicates three variables which must be considered when evaluating alcoholism in any particular group.

> 1) The group incidence (or rates) of acute psychic tensions or severe needs for adjustment of the sort that probably play dynamic roles in alcoholism and which may differ widely both in content and origin;
>
> 2) The type of normative orientation toward drinking which is embedded in the culture of the group;
>
> 3) The availability of culturally defined alternate means of adjustment (whether positively sanctioned patterns or culturally typical deviations)—referring to modes other than drinking which permit partial or total satisfaction of the severe needs for adjustment which may enter into alcoholism.[15]

It would be simple if we could conclude that because Jews do not abuse alcohol, they are void of "group incidence of acute psychic tensions." But we cannot draw this conclusion. We can conclude that Jews have a healthy "normative orientation toward drinking" embedded in their culture. As for the availability of culturally defined alternate means of adjustment, we can say there are a few, all of which seem to fit "culturally typical deviations" rather than "positively sanctioned patterns."

Looking first at Snyder's third variable, one of the most interesting theories about an alternate means of adjustment among Jews postulates that Jews substitute gambling as tension release where others (non–Jews) might choose alcohol. Adler and Goleman indicate that similar psychodynamics have been proposed for gambling and alcoholism and, in cultures where gambling is prevalent, alcoholism will seldom appear, and vice versa.[16]

Other authors have indicated a higher proportion of opiate addiction among Jews than among the general populace. One obvious fact is that opiates do not have the same "sacred" value for the Jews as does alcohol. Abuse of drugs does not carry the same insult to God inherent in alcohol abuse. "The contrasting effects of the drugs together with cultural attitudes determine the prevalence of type of addiction." [17] Or as another author states:

> Specifically, what the investigator in this field is trying to do is to discover how membership in a group sharing a certain culture predisposes one to a particular method of handling anxiety, whether 'normal' or otherwise. He is working on the problem of symptom choice.[18]

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[15] Charles R. Snyder, *Alcohol and the Jews: A Cultural Study of Drinking and Sobriety* (New Haven: Free Press, 1958), p. 185.

[16] Nathan Adler and Daniel Goleman, "Gambling and Alcoholism: Symptom Substitution and Functional Equivalents," *Quarterly Journal of Studies on Alcohol*, XXX (Sept, 1969), pp. 733–736.

[17] A. Wikler, "A Psychodynamic Study of a Patient During Experimental Self–Regulated Re–addiction to Morphine," *Psychiat Quart*, XXVI (1952), pp. 270–293 (CAAAL Abst. #6131).

[18] Albert D. Ullman, "A Sociocultural Background of Alcoholism," *The Annals of the American Academy of Political and Social Science*, CCCXV (Jan, 1958), p. 49.

It is assumed that Snyder's first variable (presence of group incidence of acute psychic tensions) does exist among Jews. Such tensions were evidenced in a 1908 study that revealed a high degree of manic–depressive psychosis and paralysis among Jews while showing a correspondingly low presence of alcoholism and epilepsy.[19] Another author reported:

> A New York mental health survey of households found that, compared with Protestants and Catholics, Jews had high rates of 'mild to moderate' psychological disorders, but low rates of more serious disorders that impaired social functioning. Alcoholism would be just one variant of the latter.[20]

We can conclude that the ". . . low incidence of drinking problems is not due to general protections against stress afforded by a traditional ethnic culture." [21]

The above mentioned studies identify neurosis among Jews living within the confines of their families and cultural environment. There have also been studies which evaluated drinking patterns of ethnic group members who were removed, however temporarily, from such surroundings. A 1942 study of World War I veterans in the V.A. hospital in Northport, Long Island, from 1936 through 1939, reviewed the relationship of alcoholism as a causative factor in psychopathy and psychoneurosis. The results showed the lack of correlation between alcoholic habits and those symptoms and discredited the theory that alcoholism causes either of the other problems consistently.[22] More interestingly for our study, it also showed high incidence of psychopathy and psychoneurosis and low incidence of chronic alcoholism for Jewish subjects evaluated.

Another study surveyed the correlation of race and ethnicity with mental disorders as the basis of rejection for service in the American armed forces during World War II. "The low rate among the Jews and Chinese is explained on the basis of religion. Drunkenness is a social disgrace in both groups." [23] Again, however, a low rate of alcoholism did not indicate a low rate of stress or mental disorder.

While Jews are in the Armed Forces (or other similar surroundings outside their ethnic community), deviant behavior is more likely to occur. The Jewish tradition of family is strong and that environment may be missed more by Jewish males than others. Snyder notes four

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[19] Bratz, "The Etiology of Epilepsy," *Neurol, Zbl.*, XXVII (1908), pp. 1063–1065 (CAAAL Abst. #3030).

[20] Wilkinson, *Prevention of Drinking Problems*, p. 213.

[21] *Ibid.*, p. 20.

[22] N. Mores, "The Alcoholic Personality: A Statistical Study," *Qarterly Journal of Studies on Alcohol*, III (1942) pp. 45–9 (CAAAL Abst. #229).

[23] R.W. Hyde and R. M. Chisholm, "Studies in Medical Sociology, III, The Relation of Mental Disorders to Race and Nationality," *New Eng J* Med, CCXXXI (1944) pp. 612–18 (CAAAL Abst. #4149).

variations of response that are likely to occur in Jews under outgroup pressures. He begins (first variation) by saying that as long as the Jewish family structure is maintained, there is little change from outgroup pressure. But, in a second variation (*i.e.* when the male member leaves for service, college, etc.), incidences of intoxication may increase. Separated from family intimacy, there is general discomfort and disorientation. There is also the social pressure to "be one of the boys." The third variation to outgroup pressure involves the response of those in different religious categories. Orthodox Jews are most likely to be strong in maintaining their allegiance to cultural norms of behavior. For the non–Orthodox, ". . . the internalization of norms and ideas antithetical to hedonistic drinking is often insufficient to sustain patterns of moderate drinking and sobriety in the face of strong situational counterpressures, such as those which arise in military service." [24] The fourth variation of Snyder indicates that a larger function of the Jewish community (again particularly Orthodox) is to curtail contacts (or the need for contacts) with non–Jews which minimizes the trend of pressures toward immoderate drinking. It is important to note here, however, that when response to outside pressures results in heavy drinking, particularly under "temporary" stress, it is not the same as compulsive or addictive drinking.[25] The belief is that, once returned to his normal environment, a Jewish individual (particularly from an Orthodox background) who has experienced temporary separation will resume cultural patterns from which he departed earlier.

Snyder spent a great deal of time studying the differences between major Jewish groups. His third variation above indicates his belief that orthodoxy is the stabilizing influence in Jewish response to outgroup pressures. The thread of orthodox life filters into every aspect of Jewish ethnic identity in such a way that even the drinking patterns, among other things, of the Conservative, Reform, and, Secularized Jews are positively influenced.[26] Consequently, ability to reject outgroup pressures is weakened in proportion to distance from the central tenets of Orthodox faith.

While we shall not investigate it here, it might be interesting to speculate that a study of psychosomatic symptoms might reveal some interesting statistics about "symptom choice" for Jews in coping with stress. Our previous studies only discuss psychological manifestations of maladjustment and it is certainly unreal to promote the idea that all Jews subjected to the types of stress these studies evaluate are victims of such personality and mental disorders. It is quite likely, I think, to guess that a large number of Jews suppress and internalize their stress

[24] Snyder, *Alcohol and Jews*, p. 155.
[25] Ullman, "A Sociocultural Background," p. 14.
[26] Chafetz and Demone, *Alcoholism and Society*, p. 87.

in ways which are less destructive mentally, but very problematic in other ways.

Some other factors of consideration are important. For instance, most drinking is done with meals. Food is more central as a stimulus for conviviality among Jews than alcohol. Alcohol is often served along with food but the focus is not on drinking per se. Of course, we have to admit that even "eating" is not a completely secular function for Jews since Jewish ritual gives great emphasis to the "feasts" of Holy Days. However, there must not exist all the same connotations about the "sacredness" of eating as about alcohol, for many Jews overeat in the same way that non–Jews overdrink—and for the same purpose—to relieve stress.[27]

It has also been suggested that members of all major Jewish groups from all nations are tied together in varying degrees by Zionism. Perhaps Zionism can be identified as a twentieth century secular Jewish orthodoxy which has been successful in helping even secularized Jews (*i.e.* Jews otherwise assimilated into the permissive, accepting American Culture) maintain their Jewish identity, and:

> Where nominal change entails the substitution of a new secular orthodoxy (*e.g.* political Zionism) for the older religious orthodoxy, without seriously disrupting Jewish social ties, sobriety may persist.[28]

Since Israel has been mentioned, it is interesting to note that there are some particular problems regarding the use of alcohol that are appearing there. First of all, the legal code, modeled and derived from the British mandate period, includes four crimes relative to the abuse of alcohol: (1) disorderly behavior while drunk; (2) the possession of any loaded firearm, knife or other deadly weapon while drunk; (3) the supply of intoxicating liquor to any person who is already drunk; and, (4) the supply of alcoholic drink to, or encouraging its consumption by, any person who is under the age of 18. In 1961, it was noted that in spite of economic and political insecurity, there were few problems of the criminal behavior described in this code.[29] A 1962 study showed a slight increase in drinking violations that suggested there was increasing consumption related to economic prosperity.[30] By 1965, alcohol problems were acknowledged and defined in the following manner:

> Although the consumption of wine has doubled and the use of brandy tripled from 1958 to 1965, the alcohol problem in Israel is still small. The compulsive drinker is rare and there is no Skid Row. Four types of alcoholism are described: 'Status Alcoholism' occurs because

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[27] Wilkerson, *Prevention of Drinking Problems*, p. 211.

[28] *Ibid, p. 140.*

[29] Albion R. King, "The Alcohol Problem in Israel," *Quarterly Journal of Studies on Alcohol*, XXII (June, 1961) pp. 321–4.

[30] R. Shuval and D. Krasilowsky, "A Study of Hospitalized Male Alcoholics," *Israel and Psychiat*, I (1964) pp. 277–92 (CAAAL Abst, #11126).

> 'brandy and other strong drinks' become status symbols to affluent middle—and upper–income groups. 'Reactive alcoholism' occurs when men in unfavorable economic circumstances find their standing as undisputed head of the family weakened because their children are better educated than they; such men may react by becoming inebriated on weekends. 'Insecurity alcoholism' occurs in people used to drinking before coming to Israel; they are likely to turn into 'habitual drinkers' if they have a psychopathic tendency. 'Evasion Alcoholism' occurs in people who have undergone great stress; they may turn to drink even when they have to face ordinary problems. The incidence of alcoholism among former inmates of Nazi concentration camps is about three times higher than in the comparable general population.[31]

This and other studies concerning drinking problems in Israel during the 1960's indicate that a large proportion of what might be labeled "Evasive Alcoholics" had experienced total breakdown of family life. Furthermore, this breakdown occurred most frequently with Jews who had emigrated from East Europe (Poland, Rumania, and Russia). [32]

Jewish drinking patterns have been studied from many other angles. Jews have been compared with other ethnic groups in America and in other countries. Variables such as generation in this country, and socio–economic status have been studied to further elucidate facts that circumscribe the Jewish attitude toward, and use of, alcoholic beverages. The "thread of truth" that appears in every study reveals that it is the integration of attitudes and patterns of consumption that permeate and stabilize the Jewish life style regarding use of alcoholic beverages. This "integration," of course, stems from the orthodox element. However, even non–orthodox Jews retain some of this influence. Certainly, this integration of attitude with behavior contributes materially to the low rate of alcoholism among Jewish people.[33]

INFLUENCE OF MODELS ON JEWISH DRINKING BEHAVIOR

The Jewish tradition of a strong family structure tends to further solidify the integration of attitudes and behaviors already discussed. ". . . the culture is in large part transmitted through the median of the small, face–to–face unit the sociologist calls the 'primary group.' " [34] Understanding the power of the family as "primary group" and the influence it yields in the rearing of children, it is easy to understand how Jewish traditions are passed from one generation to another with such enduring qualities.

As one analyzes the impact of this influence on a Jewish child, the astounding revelation is how tightly interwoven and consistent the

[31] L. Wislicki, "Alcoholism and Drug Addiction in Israel," *Brit J Addict*, LXII (1967) pp. 367–73 (CAAAL Abst. #12855).

[32] Shuval and Krasilowsky, "Study of Hospitalized Alcoholics," pp. 277–92.

[33] Ullman, "A Sociocultural Background," p. 50.

[34] *Ibid.*, p. 53.

teachings about so many areas of life are. The Jewish child is taught a value system and sees the practice of it by his parents. Moving from the theoretical to a personal model, the values are reinforcingly consistent. Research has shown that exactly the opposite happens among groups or individuals with high alcoholism experience. Conflicting attitudes toward drinking, or being taught one thing and seeing another in practice, results in strong feelings of ambivalence. When individual drinkers don't know what is expected, or when expectations differ in various settings, the result is ambivalence. "Thus ambivalence is the psychological product of unintegrated drinking custom." [35]

> . . . the record shows that attitudes of moderation and control can be effectively transmitted by parents to their children and, through them, to succeeding generations, so that this comes to be the consistent and traditional form of behavior for all members of the group.[36]

Family solidarity and reverence for moderation are the intertwined systems of social–psychological control which transmit the values we have discussed.

CONCLUSION

What can be learned from this survey that can be applied to non–Jews? Specifically, what can Christian clergymen learn that will help them minister to the alcoholic and prevent or reduce the occurrence of alcoholism?

It is obvious there is a great deal of ambivalence—the first lesson to be learned—among Christian people about the use of alcohol. While some Christians use wine ritually in worship, others do not. This represents ambivalence within the Christian community—attributable, perhaps, to the Puritan ethic.

> To understand the force of this ambivalence about drinking, it is necessary to see how deep rooted it is in American Culture, having its origin in the Puritan ethic. The Puritans, who came to America in order to practice their own religion, condemned as evil all things bringing pleasure to the senses. . . . The Puritanical ideal was superimposed upon the Anglo–Saxon cultural attitudes (as a whole characterized by heavy alcohol use) of other settlers in America, and produced a great conflict in values. This ambivalence, with resulting pressure on the individual, was increased later by the gradual destruction of old cultural barriers coupled with an increase in communication of ideas and attitudes.[37]

"The Puritan ethic of conscious control of will, personal sin, and responsibility allows no deviant behavior. Hence a problem with alcohol results in the individual's rejection and separation from the social group." [38] Once ostracized, an individual is further propelled into un-

[35] *Ibid.*, p. 50.

[36] Margaret Bacon and Mary Brush Jones, *Teen–Age Drinking* (New York: Thomas Y. Crowell Co., 1968), p. 191.

[37] Chafetz and Demone, *Alcoholism in Society*, pp. 26–27.

[38] *Ibid*, pp. 27–8

healthy patterns, following other deviant behaviors to meet life's needs and problems. "To many members (of varying Christian groups), complete opposition to alcohol does not appear to be a Christian virtue; rather it seems to be an unChristian kind of bigotry." [39]

While Jews have less of a problem with alcohol because of their religion, large numbers of Christians have more of a problem for the same reason. Note the following statement by Howard Clinebell:

> For the alcoholic, alcohol is not a symbol of the vertical dimension of life. It *is* the vertical dimension. The alcoholic substitutes a symbol—the very nature of which is to point beyond itself—for that which is symbolized. . . . Alcohol is not a symbol of his experience of a higher power; it *is* his higher power. Perhaps this is the meaning of the statement, 'Before A. A., we were trying to find God in a bottle.' [40]

Clinebell adds: "The same properties which make it a valuable religious symbol for many people also lend it to use as a substitute for religion by others, including alcoholics." [41]

I'm not implying that the Christian religious experience is always a causal factor in relation to alcoholism. Rather, I'm emphasizing that Jews have an integrated philosophy regarding the use of alcohol and many Christians do not.

Many changes in attitudes are taking place among Christian groups today. Official statements are being changed to include or reflect a position on alcohol use. More important than changing attitudes toward alcohol, however, must be a change in attitude toward the alcoholic. Contingent on this is our ability as Christian clergymen to deal effectively with alcoholism and to minister effectively to alcoholics.

There is no simplistic solution! Christian identity does not carry the same ethnic connotation as Jewish identity. There is no political or other orthodoxy that stimulates homogeneity among Christian people. Beyond this, the complex society in which we live is working to reduce the number, stability, and duration of primary relationships. Drinking, under these pressures, tends to become more of an individual matter for the purpose of conviviality.

Still, there must be some way of implementing the lessons learned in such a way that non–Jews may also benefit. Perhaps the most important thing for clergymen of all traditions is to promote integration of attitudes and patterns of use regarding alcoholic beverages that will reduce ambivalence. We must acknowledge there are others whose faith is as strong and meaningful as ours and that their different feelings and

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[39] Oates, *Alcohol—In and Out of the Church*, p.14

[40] Howard J. Clinebell, Jr., "Philosophical—Religious Factors in the Etiology and Treatment of Alcoholism," *Quarterly Journal of Studies on Alcohol*, XXIV (September, 1963), p. 476. (A complete reprint of this article appears in this issue, pp. 87–100.)

[41] *Ibid.*, p. 10.

opinions about every aspect of life, including the use of alcohol, are important and worthy of consideration. This will, at least, reduce both the internal ambivalence and the external conflict and bring us closer together in a community of faith meant to provide a channel for God's love and redemption.

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GRIEF WORK IN ALCOHOLISM TREATMENT

Lester R. Bellwood, Th.D., Ph.D

In alcoholism treatment at the Fort Logan Mental Health Center, Denver, Colo., a primary concern is to help clients do "grief work"—the process of passing through the necessary stages of grief over a loss in order to come to terms with that loss and then transcend it. A 1971 study at Fort Logan showed that at least 20 percent of all clients admitted for alcoholism started heavy drinking at the time they suffered a major loss or separation in their lives. Rather than go through the normal phases of grief work, they have generally stopped at the depression stage or skipped some of the cycle and allowed alcohol to take over, leaving them seriously in need of resolving their grief. Further evidence indicates that all alcoholic persons are in a chronic state of grief, for if a separation was not the original cause of their heavy drinking, they have incurred significant losses in the course of becoming alcoholic.

LOSSES

The need to do grief work is not limited to one who has lost a loved one. It is indicated at the time of any important loss or separation. There are four kinds of losses: (1) material loss—of any object of value; (2) physical loss, involving part of one's body, or developmental losses suffered as one passes through the stages of life; (3) psychological loss—of self–esteem, self–respect, self–confidence, or the like; and (4) loss of a significant figure in one's life, either through death or through separation.

One may call the work of normal grief the illness that heals itself; it is pain with a purpose, for grief work could never be accomplished without pain. Most authorities list at least six different components of grief in one order or another. The first is the loss itself. This is followed by shock on the part of the bereaved, after which depression ensues. Underlying the depression is always hostility or anger, which, if re-

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Reprinted by permission from the Spring 1975 issue of *Alcohol Health and Research World*, pp. 8–11, DHEW Publication No. (ADM) 75–157, National Institute on Alcohol Abuse and Alcoholism, National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

pressed, emerges in the form of guilt. Under normal conditions, the anger and guilt feelings are resolved, the depression lifts, and the bereaved completes his grief work as he goes on to reconstruction—that of gradually accepting the loss and seeking new relationships or objects to replace the old. If, on the other hand, one becomes fixated at any one of these stages, or skips one or more of them without proper resolution, he is in trouble. He becomes the victim of abnormal grief, which may take the form of alcoholism. In this case, the most effective modality for treatment may be to assign the alcoholic patient to a special group where he can engage in the constructive work of mourning.

RESPONSE TO LOSS

How does one do grief work? First, let us consider typical responses to loss. It is quite natural to experience varying degrees of shock, depending upon the severity of the loss. Of course, the need for weeping is most frequently present. It is not uncommon to experience tightness of the throat, choking, and shortness of breath. There is often an emptiness in the pit of the stomach, a feeling of lack of power in one's muscles, with sensations of weekness or tiredness. Chills, tremors, and tension may be present, with a great deal of mental pain and loneliness. Complaints that saliva won't flow and that food tastes like sand are often reported. Events seem unreal. One's responses may be disorganized or undependable, with a loss of capacity to initiate action. The whole experience may be mingled with emotions of irritability and anger. There is usually a great desire to talk about the deceased, either in good or bad terms.

All of these reactions are normal and should not cause alarm to a therapist or counselor. In fact, the bereaved should be encouraged to experience them to the fullest, with no attempt to repress any one of them, for once they are fully experienced they usually subside. If they are repressed, they may manifest themselves in many different forms of behavior which are symptomatic of abnormal grief. This tendency to repress feelings may have its roots in another natural symptom—denial. It is a very common response to death, and is revealed in such statements as "It isn't really him," or "He isn't really dead!" These are not in fact statements made as a result of deep trust in God and belief in immortality, but a denial of the loss. This denial is worthy of watching, for it may cause the bereaved to deny also the depression, anger, and guilt which are connected with the loss, and thus to block the grief work cycle.

DEPRESSION

For example, persistent severe depression is one danger signal. Many times the depression may not have external manifestations. In a group therapy setting it may be brought out into the open through

showing movies which are heavily loaded with grief experiences, or by simply discussing the six levels of grief and suggesting that someone in the group may identify with one or more of them in relationship to his own grief experience.

A very useful approach is to have the patients do a fingerpainting; in the group discussion of each individual painting, archetypal symbols revealing depression resulting from unfinished grief work may emerge and be extremely helpful. Frequently, one finds pictures with dark, dreary, or desolate colors which are symbols of depression. At times a patient will produce a solid black picture, sharply indicating depression so intense that the patient is suicidal. One will almost always find that the depression is the result of a significant loss or separation.

In therapy at Fort Logan Mental Health Center, a male patient who did not appear to be outwardly suffering from grief or depression made an austere painting of a lake at the top of a mountain with no foliage whatsoever. According to Jungian interpretation of symbols, large bodies of water are often symbolic of female figures, because they can hold life as can a female. Consequently, the therapist remarked, "Your picture gives me a feeling of loneliness. I wonder if you aren't lonely and depressed, and if in fact it is related to a woman."

Immediately, the man broke down and wept bitterly. When he regained his composure, he stated that his mother had died a year ago, and within two weeks his wife had expired unexpectedly. He said he sank into a deep depression and started drinking heavily to drown his sorrows, only to find himself completely unable to stop drinking. This patient was immediately assigned to a grief work group, and within three weeks he began to relinquish his longing for the loved ones whom he had lost. No longer feeling the need for alcohol, he developed new relationships to replace his wife and mother. He is still sober after five years.

Another male patient came to the division for treatment following a long drinking episode which was triggered by the deaths of his wife and teenage son, only a few days apart. His depression was obvious; he verbalized his loss fluently. At first there was no evidence of feelings of anger causing his guilt, for he was apparently "locked in" with repressed hostility, showing no evidence of any attempt at reconstruction. When confronted in therapy about the absence of anger in his external mourning, he immediately denied any such submerged feelings. This gave a clear indication that anger was the missing link in the chain of grief work yet to be accomplished.

It was not long until the "if" syndrome began to emerge in such statements as "If I hadn't taken that extra job I would have had more time with them. If I had taken my son to the doctor sooner, he wouldn't

have died." This "if" game is definitely indicative of the presence of guilt resulting from repressed hostility. Consequently, the therapist urged, "I thought you said you weren't angry or hostile, but look at your feelings of guilt!"

At that point the anger emerged in full force. "You're damned right I'm angry!" he fumed. "I see what you mean now! I'm so angry at myself that I could kill myself for being so shortsighted!" He spent the rest of the hour beating and blaming himself for the death of both his wife and son. As he began to unwind and logically see that in no way was he really responsible for either death, he came out with the statement, "Gee, I don't feel so depressed or guilty any more. Why?"

The obvious answer is that the recognition of his hostility, both in verbal expression and in emotional experience, had resolved the guilt and lifted the depression. He too had made a fingerpainting earlier in therapy. He had painted a huge towering tree with expansive branches. Trees are often symbolic of female figures, for they hover like a mother hen. Later, after he saw the tree as symbolic of his longing for the protective arms of his dead wife, he suddenly said, "I am going to have to get another tree!" This indicated that he was nearing completion of his grief work and was ready to go on to reconstruction.

ANGER PHASE

Some alcoholic persons become "hung up" on the anger phase of their grief, and grow furious with uncontrolled hostility, finding themselves totally unable to complete the job without professional help. A good example is a male patient who was committed on a court order for treatment. According to the case history the man's son was killed in a road collision while riding in a car driven by the boy's mother. The other car was being driven by a neighbor. The patient blamed both drivers for his son's death. Consequently, he would get drunk, beat up his wife, and do acts of violence to the neighbor. Because of the nature of his problem, the patient was scheduled for psychodrama to accomplish the task of grief work. He was allowed to reconstruct the scene of the accident in every detail. In the spontaneity of the stage without script, he was permitted once again to express his hostility toward his wife and neighbor. Then he was asked to reverse roles, first playing the part of the wife, and then of the neighbor, so that he experienced how it felt to be in their shoes, as targets of his invective. Large beads of sweat rolled down his brow as he took each part. Suddenly, he fell prostrate at the feet of his fellow patients who were playing the roles of wife and neighbor. He began weeping vehemently, "My God! My God! What have I done? That was a freak accident and no one's fault! I could have been in either of your shoes!" and he begged them to forgive him.

Needless to say, his hostility towards them was resolved, but

then he had to cope with the new emotion of guilt for having blamed them. The problem was resolved when the wife and neighbor were called in the same day, and all three embraced in an expression of love and forgiveness, thanking God for a miracle. The patient's grief work was over, and so was his drinking.

UNRESOLVED GRIEF

Still other patients in the course of their mourning move from the trauma level to reconstruction, skipping over their feelings of depression, hostility, and guilt. Eventually they find themselves in a state of unresolved grief, with the need to return at a later date to complete their mourning. This is exemplified by a patient whose wife divorced him. He walked out, leaving her with all their possessions, thinking that his unreasonable generosity took care of his guilt. He acted out his hostility sexually by immediately remarrying. Almost within days of the second marriage, all of his unresolved feelings were transferred to the new relationship in a distorted form, and alcohol took over. He had to return to the depression he felt from the loss of his first wife, and work through the hostility and guilt underlying the depression. Only then was he able to resolve the transference and have a significant relationship with the second wife without alcohol.

To some people, separation means rejection or punishment. Thus, the person doesn't feel worthy of new relationships and is incapable of finding them. He has no strong acceptance of himself. Consequently, he may identify with the departed one and take upon himself the characteristics of that person. If the loss was a death, he may even feel that he too has cancer, heart trouble, or whatever caused the death.

One alcoholic person's father died when he was four years old, and the mother idealized her departed husband. The boy attempted to take on the fantastic image of his father rather than be himself. This blocked his development as a person, and he could not free himself, for he could never come up to the "godlike" qualities of the father. In time he began to rely more and more on alcohol in order to resolve his feelings of low self–worth and self–esteem. Before he could go on to reconstruction and be himself, he had to go back through all six phases of grief and unlock his hostility for having had to try being someone else just to please his mother.

THE DYING

Too frequently the need of a dying person to do grief work is overlooked. How often in dealing with alcoholic persons in the final stages of cirrhosis of the liver do we give them that opportunity? Many of these individuals suffer a death far more terrifying than it would have been if someone were there to help them do their grief work. The dying, too, need to pass through all six phases. When they do, the peace and

infinite trust which they manifest in dying is astonishing, contrasted with the terror experienced by those not given the opportunity to do grief work.

In all cases of grief work there is something about the successful completion of the cycle that establishes a deeper trust in the infinite, whether this is expressed in terms of a reality greater than oneself, a feeling of well-being, or—as in a remark which is not uncommon—"I feel like God is inside me and all is well!"

LOSS OF THE BOTTLE

Another significant loss among most alcoholic persons is also overlooked—the loss of the bottle. When the alcoholic person discovers that for the rest of his life he can no longer depend upon alcohol to sedate or release his emotional feelings, the shock he experiences is unbelievable. He still has to work through the same old emotions of depression, anger, and guilt before he can resolve his grief. It is important to be aware of these dynamics every time the alcoholic person approaches a sobriety anniversary (or "birthday" in the terminology of Alcoholics Anonymous), for at that time he may face danger of regressing and getting drunk, because once again he may experience grief from loss of the bottle. For that reason, it is good to assign an alcoholic person approaching a "birthday" to a grief work group where he can once again review and experience all emotions resulting from the loss of the bottle.

The symptoms of abnormal grief are too numerous for complete listing here. However, close analysis of depression, hostility, and the like will often reveal that one or more of the six phases of grief work have been left unresolved. The sooner one begins his grief work, the better, for normally it takes three weeks before the client begins to accept the loss and move on to reconstruction. The longer the task is delayed, the more difficult and time consuming it is. Every alcoholism clinical program should be sensitive to the need for providing special modalities and groups to treat the alcoholic patient in an acute or chronic state of grief.

SUMMARY

Grief work is the process of passing through the successive stages of grief over some loss. The stages may be summarized as the loss itself, shock, depression, anger, guilt, and reconstruction. A person who is fixated at one stage or skips one without proper resolution must often be helped to recognize the situation and perform the omitted grief work in order to effectively adjust to his loss. Unresolved grief work has been found to be an important factor in the problems of at least one–fifth of the alcoholic persons treated at the Fort Logan Mental Health Center, Denver, Colo. Group therapy, art therapy, and psychodrama are among the modalities used in grief work at the center.

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PHILOSOPHICAL—RELIGIOUS FACTORS IN THE ETIOLOGY AND TREATMENT OF ALCOHOLISM

Howard J. Clinebell, Jr., Ph.D.

References to philosophical and religious factors in the causation of alcoholism have been relatively rare in the literature. The view that such factors exist and are of significance in understanding alcoholism in both its etiological and treatment aspects underlies the present attempt to explore these factors, and leads to a consideration of the ways in which the alcoholic handles his existential anxiety.

Lolli has suggested that the problems of neurotic and existential anxiety are complexly intermingled in the causation of alcoholism.[1] The suggestion that three types of anxiety—neurotic, historical and existential—are involved in alcoholism is one that I offered and elucidated in a preliminary way in another statement.[2] The purpose of the present essay is to set forth a tentative theoretical structure which may prove to be useful in understanding the role of existential anxiety and its relationship to neurotic anxiety in the alcoholic.

BACKGROUND CONSIDERATIONS

Several types of evidence contributed to my curiosity concerning the broad area of the relationships between alcohol and alcoholism, on the one hand, and such matters as religious strivings, fear of death, loneliness and meaninglessness, on the other. One was a statement by Bill W., co–founder of Alcoholics Anonymous: "Before A.A. we were trying to find God in the bottle." Another datum was the familiar paragraph from William Jame's Gifford lectures: "The sway of alcohol over mankind is unquestionably due to its power to stimulate the mystical faculties of human nature, usually crushed to earth by the cold facts and dry criticisms of the sober hour. . . . Not through mere perversity

[1] G. Lolli, "Alcoholism as a Disorder of the Love Disposition," *Quart J Stud Alc*, 17:96–107, 1956.

[2] H.J. Clinebell, Jr., *Understanding and Counseling the Alcoholic* (New York: Abingdon Press, 1956) pp. 61–64, 147–149.

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do men run after it . . . the drunken consciousness is one bit of the mystical consciousness." [3]

Abundant material from cultural anthropology, as well as from the history of religions, points to the affinity between alcohol and religion in many cultures. Horton noted that, if one asks a native in a primitive or semiprimitive society why he values alcohol, he will probably say it is because his ancestors found it good or because it was given to his people by the gods.[4] Jellinek has described the symbolic aspects of alcoholic beverages and has pointed out that many ancient cultures regarded wine as the "stream of life." [5] In the Greek pantheon, Dionysus, god of wine, also was related to the afterlife. An immensely popular deity, he was believed to suffer, die and rise again from the dead.[6] Goodenough has pointed out that certain Jewish gravestones of the Hellenistic period bear carvings of drunken men, apparently serving as meaningful symbols of death–transcending experiences.[7] The use of wine in the Christian tradition—*viz.*, in the sacrament of the Lord's Supper in some Protestant groups and in the Roman Catholic Mass—is another illustration of the link between alcohol and religion.[8]

Moving from the symbolic and ritual uses of alcohol to its addictive use, the clinical evidence is suggestive. The prominence of the fear of death in the symptomatology of a number of early–stage alcoholics with whom I have counseled has seemed impressive. For example, a single woman in her early forties who was still able to hold a responsible job, but was becoming concerned about her rapidly increasing dependence on alcohol, sought help. Her discussion of her childhood included reference to a persistent fear of being outside under the stars at night. Closer examination of this and subsequent fears disclosed a common underlying theme—an intense fear of dying. Both neurotic and existential elements seemed to be present.

The striving for a kind of pseudo–mystical experience through alcohol has been evident in a number of alcoholics counseled at various stages in their addiction. One man in his early 30's phrased it this way: "When I reached a certain point in a drunk, I felt as though I were on the edge of a beautiful land. I kept drinking to try to find it. I never made it, but I had to keep trying."

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[3] W. James, *The Varieties of Religious Experience; A Study in Human Nature* (New York: Longmans, Green, 1902) p. 378.

[4] D. Horton, "The Functions of Alcohol in Primitive Societies" in *Alcohol, Science and Society* (New Haven: *Quart J Stud Alc*, 1945) ch 13.

[5] E.M. Jellinek, *The Disease Concept of Alcoholism* (New Haven: Hillhouse Press, 1960) p. 150.

[6] E.R. Pike, *Encyclopedia of Religion and Religions* (New York: Meridian, 1958) p. 125.

[7] E.R. Goodenough, *Jewish Symbols of the Greco–Roman Period* (New York: Pantheon, 1956).

[8] I am not suggesting that the link between alcohol and religion is a direct causal factor in producing alcoholism. There is some evidence that the ritual uses of alcohol may actually deter the development of alcoholism in certain cultures (among orthodox Jews, for example). The fact that the use of alcohol is often related to religious festivals and practices attests to its value as a religious symbol. The same properties which make it a valuable religious symbol for many people also lend it to use as a substitute for religion by o[illegible]s, including alcoholics.

The final item of empirical evidence, pointing to a link between alcoholism and religion, is the well–known but only partially explained fact that the most effective program ever devised for treating alcoholics is essentially a spiritual program—A.A. There may be other dimensions to the explanation of this fact that previous studies, largely sociologically and psychologically oriented, have found. Intensive study of A.A. experiences in general and the so–called "spiritual angle" in particular may prove to be productive, especially if undertaken by those whose training bridges the disciplines of the behaviorial sciences, on the one hand, and philosophy, comparative religion and theology, on the other. Studies by those within the discipline of the psychology of religion may produce new illumination of the dynamics of this striking social phenomenon.

EXISTENTIAL ANXIETY AND ALCOHOLISM

When ancient man stumbled by accident on the product of fermentation, he must have felt that strange, even miraculous, things were happening to his inner world. When he drank the juice of fruits, grains or honey which had been left in a warm place for a time, his fears and burdens lost their weight. His painful awareness of disease, death and injustice lost its sting. The monotony and drabness of his life were interrupted. He felt lifted out of the horizontal earth–boundness of his daily existence into a temporary experience of the vertical dimension of life. Small wonder that he regarded the substance that could produce these effects as a mysterious gift of the gods.

In a much later period, Thomas Wolfe gives a vivid picture of the way in which alcohol gives some persons a powerful experience of transcending their feelings of weakness and finitude. Intoxicated for the first time, Eugene, in *Look Homeward, Angel*, muses:

> In all the earth there was no other like him, no other fitted to be so sublimely and magnificently drunken. . . . Why, when it was possible to buy God in a bottle, and drink him off, and become God oneself, were not men forever drunken? [9]

The similarity of this statement to that of Bill W. is noteworthy.

Fromm holds that the emergence of man from the womb of nature into self–awareness, reason and imagination brought with it the burdens of a sense of estrangement from nature and one's fellows.[10] Nietzche's insight is relevant at this point: "Under the charm of the Dionysian not only is the union between man and man reaffirmed, but Nature which has become estranged, hostile or subjugated, celebrates once more her reconciliation with her prodigal, man." [11] A part of the

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[9] T. Wolfe, *Look Homeward, Angel* (New York: Scribner's 1947) p. 525.

[10] E. Fromm, *Psychoanalysis and Religion* (New Haven: Yale University Press, 1950) p. 22.

[11] *The Works of Nietzche* (New York: Tudor, 1931) pp 172–173.

charm of alcohol is its ability to impart the Dionysian and thus to restore for a time a sense of unity within oneself, with others and with nature.

It was undoubtedly because of its power to give experiences of the ecstatic and the transcendent that alcohol found such widespread use as a symbol of these elements in religion. Wine, it should be noted, was and is often used in those religious rites and festivals related to the mysteries of man's existence, such as birth, marriage and death. The roots of such practices are deep. That they have survived through the centuries attests to their functional value as meaningful symbols for the participants. It may be that when alcohol loses its associations with the mysteries of life (and the ritual ways of handling them), as it has for many of our culture, it tends to be used in an unrestrained manner.

It is the central thesis of this discussion that one of the significant factors in the etiology of alcoholism is the attempt to satisfy religious needs by a nonreligious means—alcohol. This is to say that the spiritual problems of the alcoholic are not merely derivative from or symptomatic of his underlying personality problems, but constitute genuine problems in their own right. Religious factors cannot be understood adequately when isolated from other factors—sociological, psychological, biochemical—but constitute a significant dimension of a depth understanding of some if not all alcoholism.

For the alcoholic, alcohol is not a symbol of the vertical dimension of life. It *is* the vertical dimension. The alcoholic substitutes a symbol—the very nature of which is to point beyond itself—for that which is symbolized. Alcohol is not a symbol of his experience of a higher Power; it *is* his higher Power. Perhaps this is the meaning of the statement, "Before A.A. we were trying to find God in a bottle."

An exploration of the ways in which this operates requires an analysis of the nature of man's religious need.[12] There are at least three aspects of this fundamental need: (1) *The need for an experience of the numinous and the transcendent.* Ruth Benedict has referred in her anthropological writings to the belief in "wonderful power" which was ubiquitous among the cultures she studied. This need to feel that there is something wonder–full, transcending the mundaneness of life, is what was meant earlier by the "vertical dimension." (2) *The need for a sense of meaning, purpose and value in one's existence.* Frankl calls this the "will–to–meaning" and sees it as more basic in man than Freud's will–to–pleasure or Adler's will–to–power.[13] (3) *The need for a feeling of deep*

[12] This need is so described on the assumption that a religious–philosophical answer represents the only adequate means of satisfying the need. (Such an answer is in no sense limited to the institutional expressions of religion.) The term "philosophical–existential need" could be substituted and perhaps would make for greater clarity. This need is existential in that it grows out of the very nature of man's existence as a self–aware, valuing creature who knows that he will die. The term philosophical is used in the sense of *Weltanschauung.* The term "religious need," as used in this article, is an abbreviation for "religious-philosophical–existential need."

[13] V.E. Frankl, *The Doctor and the Soul* (New York: Knopf, 1955).

trust and relatedness to life. Maslow uses the phrase "oceanic feeling," in his discussion of the self–actualized person, to describe the experience of being a part of the whole universe.

The source of these three elements of man's religious need is his existential anxiety. Anxiety in general is the response of the human organism to anything that is perceived as a threat to what one regards as essential to one's welfare or safety. Pathological (neurotic) anxiety arises when contradictory impulses, desires or needs clamor simultaneously for expression or satisfaction. It is the result of inner conflict. It serves the function of keeping material that is unacceptable to the self–image repressed. In contrast, existential anxiety is nonpathological or normal anxiety. It arises from the very nature of human existence. Man is the animal who knows he will die. He is trapped by his rootage in nature. He is subject to its forces of sickness, pain and death, and he lacks what Big Daddy, in Tennessee Williams' *Cat on a Hot Tin Roof*, calls the "pig's advantage"—*viz.*, ignorance of his mortality. The theme of existential or nonpathological anxiety has been discussed by thinkers holding to diverse metaphysical presuppositions, including Kierkegaard, Tillich, Fromm, Horney and May. The German philosophical literature refers to this anxiety as *Urangst.* Erik Erikson calls it the "ego chill." Tillich writes:

> Man's essential loneliness and seclusion, his insecurity and feeling of strangeness, his temporality and melancholy are qualities which are felt even apart from their transformation by guilt. They are his heritage of finitude.[14]

Existential anxiety results from threats to man's very being. According to Tillich these threats come from three directions: the threat of fate and death, of emptiness and loss of meaning, of guilt and condemnation.[15]

There is no psychological answer to existential anxiety. It cannot be eliminated through psychotherapy. It is existential in that it is inherent in man's very existence as a self–aware being. But its impact on the individual can be either constructive or destructive, a stimulus to creativity or a paralyzing force. Which it is depends on the way it is handled by the individual. Existential anxiety is not the result of the peculiar threats of our period of history, since it is a part of man's "heritage of finitude" in all periods of history. However, as will be discussed subsequently, the particular combination of factors which cause our period of history to be an "age of anxiety" make it more difficult to handle existential anxiety constructively. There are only religious or pseudo–religious ways of handling this kind of anxiety.

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[14] P. Tillich, *Shaking of the Foundations* (New York: Scribner's, 1948) p. 170

[15] P. Tillich, *The Courage to Be* (New Haven: Yale University Press, 1952).

Pseudo–religious ways eventually fail. The alcoholic employs a pseudo–religious way which, in its failure, produces an increase of both his existential and his neurotic anxiety.

As the alcoholic's illness progresses, he tends increasingly to handle all three aspects of his religious need by means of alcohol. First, his need for a sense of the numinous and the transcendent is satisfied partially and temporarily by his experience at certain stages of intoxication. This is the import of the quotations from William James, above, and from the young alcoholic who felt himself to be on the edge of a beautiful land. In her autobiography, a remarkable woman alcoholic, using the pseudonym Elizabeth Burns, writes: "Liquor wasn't a crutch for Liz, it was an exit. A quick flight to a world of her own making. . . . It wasn't that this present world was too much for her; it was that it wasn't enough." [16]

The second aspect, the alcoholic's need for a sense of meaning in his life, is also handled by alcohol. In trying to explain the function of alcohol in his life to Big Daddy, his son Brick exclaims: "A drinkin' man's someone who wants to forget that he isn't still young and believing." A paraphrase of this would be: An alcoholic lacks a sense of meaning in his life. He knows he is moving toward the day he will die. Alcohol lets him forget his emptiness and painful awareness of his mortality.

But alcohol for the alcoholic does more than provide the balm of anesthesia. Increasingly it provides a summum bonum to fill the value–vacuum (Frankl) in his inner world. It becomes *the* value in his bleak inner life. But a vicious cycle is established by this use of alcohol. The relative meaninglessness, which makes alcohol so attractive as a value substitute, is only magnified as other values are squeezed out of his life by alcohol addiction.

The same kind of vicious cycle operates in the third area of his religious need satisfaction—the satisfaction of the need for experiences of trust and relatedness. The alcoholic who reads John Donne's familiar words, "No man is an island," may sneer, "Oh, yeah?"—for he feels exactly that: a lonely island, a clod cut off from the mainland of humanity. He feels like Camus' Stranger, as though wandering in a foreign land where he does not know the language and has no possibility of learning it. Through alcohol he experiences a temporary but highly valued experience of unity. This includes the unity of psychological and physiological satisfactions achieved by regression to the oral level of infancy, to which Lolli refers.[17] At earlier stages of intoxication it also includes feelings of closeness to other people. But when the magic

[16] E. Burns, pseud, *The Late Liz; The Autobiography of an Ex–Pagan* (New York: Appleton–Century, 1957; Popular Library Edition, 1961), p. 127.

[17] G. Lolli, "The Addictive Drinker," *Quart J Stud Alc*, 10: 404–414, 1949.

moments pass, the alcoholic discovers that the gulf is wider and the isolation deeper than before. Yet he is trapped, since alcohol is the only way he knows to overcome his cut–offness even for a brief time.

A chemical pseudo religion for the alcoholic, alcohol is a Janus–faced god. Eventually it shows its hidden face—the face of the devil, so far as the alcoholic's trust in it is concerned. It may be that it is when alcohol loses its pseudo–religious power—its power to bring unity, meaning and transcendence—that the alcoholic "hits bottom." He can no longer overcome his neurotic or his existential anxieties by its use. His god has betrayed him and his ego is exposed to the full chill of ultimate anxiety.

It is pertinent to ask why the alcoholic turns to alcohol in the attempt to handle his existential anxiety. We live in a period of history when it is not easy to find genuinely religious answers. Contemporary religion in the West has lost much of the sense of the numinous and the transcendent. To use Ruth Benedict's two categories for describing religions, the Apollonian has taken over, the Dionysian has been squeezed out. In Jungian terms, the masculine (reason, ethics, logic, controls) has become dominant; the feminine (feeling, giving, mothering, accepting) has been repressed. Many contemporary religious expressions are pale and anemic, lacking in the ecstatic, the mystical, the numinous. When religion loses its spine–tingling quality, alcohol is substituted by many. The prayer of St. Augustine, "Oh! that Thou wouldst enter into my heart and inebriate it . . ." has wistful overtones for modern man.[18]

The contemporary crisis in values makes it difficult for many persons to find a philosophy of life that is so vital it bleeds when cut. Community consensus has been a casualty of rapid social change, urbanization and high population mobility. It is not an easy time for the individual to find what Fromm calls "a frame of orientation and an object of devotion." [19] The breakdown of a strong sense of community is another aspect of our times which makes it difficult to find relatedness. In his review of Peter Viereck's book, *The Unadjusted Man: A New Hero for Americans*, Geoffrey Brunn writes: "Ours is an orphan age, severed from its historic past by the transforming impact of dynamic technology. Today every individual in the 'lonely crowd' is haunted by a sense of desolation and incommunicable singularity." [20] Our much bewailed conformity is a symptom of the breakdown of community—the uprooting of those relationships of mutual trust within which existential anxiety can be handled constructively and self–esteem can flower.

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[18] *Confessions of Saint Augustine* (New York: Pocket Books, 1952).
[19] Fromm, *Psychoanalysis and Religion*, p. 21.
[20] *Sat Rev Lit*, 5 Jan 1957, p. 20.

Tillich summarizes the impact of these general characteristics of our times, so far as existential anxiety is concerned:

> The anxiety which, in its different forms, is potentially present in every individual, becomes general if the accustomed structures of meaning, power, belief and order disintegrate. These structures, as long as they are in force, keep anxiety bounded within a protective system of courage by participation. . . . In periods of great changes, these methods no longer work.[21]

The general factors described above obviously affect all of us, including the alcoholic and those who would help him. But the alcoholic appears to be particularly devastated by the impact of his existential anxiety and two factors seem to account for this. On the one hand, his existential terror of nonbeing is complicated by a heavy burden of neurotic fear of death resulting from psychological damage during the oral period. On the other hand, because of his exaggerated dependency–autonomy conflict, he is unable to avail himself of the experiences in adolescence and young adulthood which would help him handle his anxiety constructively. An examination of these two factors is in order at this point.

The psychoanalytic view of alcoholism points in the direction of a basic disturbance of the mother–infant relationship in the first year of life. Because of some inadequacy in the quality of this relationship, the prealcoholic did not develop what Erik Erikson has called "basic trust." He did not experience the world as trustworthy. Basic trust constitutes the foundation for all subsequent relationships of trust, including trust in God. The extreme narcissism of drinking alcoholics has been noted by many students of the subject. This is directly related to the lack of basic trust. The person who regresses to narcissism when his self–esteem is threatened, as the alcoholic does, is one who sustained a psychological injury during that period when narcissism was normal, the first year. Because of this injury, the person continues into adulthood yearning for the "undifferentiated pleasure of body and mind" which were in short supply during the nursing period.[22] From the threat of his very existence which is present in the deprivation of adequate love–sucking–security–warmth, the individual develops terrible fears of dying mixed with intense rage feelings toward the object perceived as depriving. It is noteworthy that many adult alcoholics respond as though the entire world of relationships were a bad breast, a depriving mother.[23] Such alcoholics form impossibly demanding dependencies and then feel angry and rejected when their grandiose demands are not met.

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[21] Tillich, *The Courage to Be*, p. 62.

[22] Lolli, "Alcoholism as a Disorder," p. 99.

[23] Melanie Klein's work on the concept of the good and bad breasts is relevant at this point (*Envy and Gratitude; A Study of Unconscious Sources* [New York: Basic Books, 1957]).

In the case of the infant who experienced the outside world as untrustworthy, his only feeling of safety was that which he could create in his inner world. Because he was actually so weak and dependent on others, he had to fantasy himself as very strong. Freud used the phrase "His Majesty the Baby" in this connection.[24] In order to find even the illusion of safety, the baby retreats into a world where he is his own love object. His narcissism is an attempt to protect himself from the fear of death which is ever present.

The deeper the alcoholic regresses in an individual binge and in the progression of his illness, the more complete the narcissistic focus of his love energy becomes. But this very regression to the infantile defense of narcissism exposes him to the terrifying giants and demons of the infant–level inner world. The overwhelming "nameless" fears of advanced alcoholism can be understood in this framework of thought. The intense fear of dying and devouring rages toward the depriving object are revived in the alcoholic. Only added alcohol–induced grandiosity can even begin to hold them in check. Spiraling waves of feelings of omnipotence are but desperate attempts to cope magically with the fear–giants and cannibalistic rages of the infantile world (which is also the world of psychosis). Thus his existential anxiety is compounded and made unmanageable by his oral–level neurotic fear of death.

DEPENDENCY CONFLICTS AND SECONDARY TRUST

The second reason why the alcoholic is peculiarly exposed to his existential anxiety is that his extreme dependency–antonomy conflict prevents him from forming healthy dependency relationships. McCord and McCord, on the evidence from a longitudinal study of alcoholism, based on data from the Cambridge–Somerville delinquency prevention project, conclude: "The major force which seemed to lead a person under heavy stress to express his anxiety in alcoholism was the erratic frustration of his dependency desires." [25] The original project, beginning in 1935, included 650 boys, both "normal" and "predelinquent." By the time of the analysis of the data, about 25 years later, 10 percent of the subjects had become alcoholics. But a lower percentage of those who experienced overt rejection by their mothers eventually became alcoholics than of those whose mothers were alternately loving and rejecting. One–third of the latter group had become alcoholics in their 30's. As Pavlov and others have demonstrated, the erratic, alternate frustration and satisfaction of a need enhances the strength of that need. McCord and McCord reason that the prealcoholic is involved in an endless quest to satisfy powerful dependency needs which, in our culture, are unac-

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[24] It is noteworthy that the context of Freud's use of this phrase was a discussion of the manner in which the parents encouraged the child's feelings of omnipotence in order to fulfill their own frustrated narcissism. (*Complete Works*, Vol 14, p. 91.)

[25] W. McCord and J. McCord, *Origins of Alcoholism* (Stanford, CA: Stanford University Press, 1960), p. 152.

ceptable to males. Alcohol is highly functional in the psychic economy of such a person because simultaneously it can give him feelings of dependence and allow him to maintain his image of rugged virility by "drinking like a man." It is when, through the effects of prolonged excessive drinking, the self–image of the independent he–man breaks down, that alcoholism develops.

McCord and McCord divided the boys in their study into Protestant–Catholic groups and the parents of each of these into strong–weak religious interest. They found that approximately equal percentages of Protestant and Catholic boys eventually became alcoholics, that the strength of the father's religion had no relevance, and that the same applied to the strength of religious interest by the Protestant mothers. In the case of the Catholic subjects, however, only 4 percent of those whose mothers' religion was rated "strong" became alcoholics, whereas 21 percent of those whose mothers' religion was rated "weak" became addicted. The investigators believe that this outcome is related to what sociologists have called the "Protestant ethic," which has become the heart of middle–class values for most Americans of all faiths. This ethic is characterized by an emphasis on success achieved through masculine independence, competition and self–reliance. These values tend to increase the prealcoholic's rejection of his own dependent side. Those strongly influenced by Catholicism with its emphasis on feminine symbols, dependency and being a part of a supernatural organism, have a channel for satisfying their dependency needs at the same time that they assert their independence through masculine success in their work.

In those cases in which the Protestant ethic dominated the home, the prealcoholic probably experienced great difficulty in finding satisfying dependency relationships in the church or in a meaningful relationship to a higher Power. McCord and McCord found that, for the most part, the alcoholics were raised by parents who were nominally religious but lacking in a deep commitment to their faith. They conclude:

> Raised in such an environment, it is unlikely that the prealcoholic would place much reliance on the church. Thus, one major outlet of his conflict—submergence in a strong religious faith—would be denied to him. Unlike the strongly religious person, the prealcoholic would tend to withdraw from the comforts of the church; he could not express his dependent longings by seeking direction from God, the priest, the minister or the elders. He could not find, in the church, the sure direction and guidance that he lacked in his early life.[26]

One might say that the prealcoholic's early problem with his mother prevented him from finding the experience of trust in "mother church." The same could be said for the other social institutions in which

[26] *Ibid.*, p. 155.

trust–full relationships are available for adolescents and adults in our culture. The person who is not a prealcoholic and who carries major deficiencies in the area of basic trust from his early life can find periodic reaffirmation of trust in religion. Erikson, in a discussion of "the sense of inner identity," states:

> We must ask ourselves what the social institutions are which support the individual in the basic conflicts . . . and which give him continuing collective reassurance when his personal development may have left a residue of insecurity. There can be no question but that it is organized religion which by way of ritual methods offers man a periodic collective restitution of basic trust which in adults ripens to a continuation of faith and realism.[27]

This second chance at experience of trust is apparently relatively unavailable to the prealcoholic.

People shape their personal religion in terms of their inner needs. The alcoholic provides a vivid illustration of this general principle. His religious life tends to reflect his narcissism and his dependence–autonomy conflict. He often expects God to take care of him in infantile, magical ways. He tries to use God as an overprotective grandmother whose main function is to extricate him from alcoholic scrapes scot free. He makes impossible demands, expects a special set of rules–of–the–game, and then feels rejected when God does not "come through" according to his demands. His religion both reflects and enhances his narcissistic self–worship and his dependency conflict. Rather than allaying anxiety it increases it because it operates in the same manner as his neurosis. The underlying meaning of much alcoholic atheism seems to be, "All right, if you won't take care of me like a child, I'll show you! I'll destroy you by the magic of thought—by not believing in you!"

Blocked from finding normal dependency and trust–producing relationships, the alcoholic is left at the mercy of his neurotic and his existential anxieties. Between these two forms of anxiety there is a reciprocal relationship. As Tillich points out, a high degree of neurotic anxiety renders one hypersensitive to the threat of non–being and, conversely, "those who are empty of meaning are easy victims of neurotic anxiety." [28] As he puts it, neurotic anxiety may be seen as a way of avoiding non–being by avoiding being (or defending oneself against the fear of death by not being fully alive). As we have seen, the alcoholic's extreme dependency conflict makes him unable to form trustful relationships. He is too concerned with hiding his dependency, too angry with frustrating dependency objects. The effect is circular: the more he is cut off from trustful relationships, the more his dependency cravings

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[27] E. Erikson, "On the Sense of Inner Identity" in Knight and Freidman, eds, *Psychoanalytic Psychiatry and Psychology*, Vol 1 (New York: International University Press, 1954), p. 353.

[28] Tillich, *Courage to Be*, pp. 67 & 151.

spiral, and with them his anger at depriving parent–symbols. The angrier he feels, the more cut off he must be to protect himself from expected retaliation. This spiraling mingles with the spiraling impact of existential anxiety in the advancing stages of the illness.

SURRENDER AND THERAPY

The key to understanding the psychodynamics of recovery, how some alcoholics escape from the self–perpetuating mechanism, is the concept of "surrender" which Tiebout has explored extensively.[29]

The phenomenon which he describes has been observed by various workers in the clinical encounter. Using Tiebout's important contributions as a foundation, an alternative approach to understanding the nature of surrender will be set forth. The alcoholic "hits bottom"—*i.e.*, his pseudo–religious solution no longer functions effectively and, at a deeper level, his narcissistic defenses no longer protect him from his fear of death and meaninglessness. The surrender experience, which may occur at this point, has two essentials: First, the unconscious renunciation of the disintegrating defense of infantile narcissism, which he gives up in order to avoid the overwhelming infantile anxieties to which this regression exposes him. Second, in hopelessness, the alcoholic makes a desperate leap. One alcoholic gave this description of the experience: "It's a leap of fear. You leap the chasm blindly, not knowing what's on the other side. Fear is pushing you and hope is pulling you." Another put it aptly when he described his experience as "letting go of my I–ism." He went on to describe the change in his distorted view of the world of relationships. During his drinking, his world had been peopled by depriving mother–figures. Having taken the leap toward trust, he discovered in A.A. that trustworthy relationships were available, that he could distribute his dependency within in the group, and that he could participate in the give as well as the take of relationships. For him, as for many alcoholics, this was a strikingly new experience. In effect, he broke the vicious cycle of spiraling isolation and anger, "rejoined the human race," and thus acquired new and more effective ways of handling his anxiety.

Particularly significant, so far as the present discussion is concerned, he learned in A.A. an effective way of handling his existential anxiety. This happened gradually through the so–called "spiritual angle." During the narcissism of active alcoholism, he had become his own mother, his own god. The essence of surrender is to stop playing god, or rather, to let go of the need to play god. The A.A. program helps the alcoholic curb his tendency to retreat to infantile, magical religion. It accomplishes this by suggesting to him that he line up his life with

[29] H.M. Tiebout, "Surrender Versus Compliance in Therapy; With Special Reference to Alcoholism," *Quart J Stud Alc* 14:58–68, 1953; "The Ego Factors in Surrender in Alcoholism," *Quart J Stud Alc* 15: 610–621, 1954; "Alcoholics Anonymous—An Experiment of Nature," *Quart J Stud Alc* 22:52–68, 1961.

reality rather than expect reality to adapt itself to him. This is the significance of the 11th Step of the A.A. program: ". . . praying only for knowledge of His will for us and the power to carry it out." This, like the other aspects of the A.A. "spiritual angle," assists the alcoholic in building an approach to a higher Power that is the exact opposite of his typical approach during his drinking days. The alcoholic develops humility and he begins to grow in his ability to trust. His spiritual growth occurs, as such growth nearly always does, in a group committed to spiritual values. The A.A. group thus gives the individual another opportunity to establish a trustful relationship with a higher Power. Like a good family, the group symbolizes, incarnates and communicates the acceptance of the higher Power. As his relationship with the higher Power grows, it reinforces his ability to trust people and to become a giving person. By staying in a dependent relationship with the higher Power, he is helped to retain his humility and to resist the temptation to return to narcissistic self–idolatry and to drinking.

Yet the surrendered alcoholic must continue to exercise vigilance to avoid losing his humility. The underlying problem of infantile narcissism is not resolved but instead is walled off in the experience of surrender. When deep–seated anxieties are aroused by threats to his self–esteem or by failure to grow spiritually, the old temptation to regress to his primitive defense and curse still remains. This accounts for the necessity which most A.A. members feel to "work the program" continually, even though their sobriety has been stabilized for years.

As relationships of trust are established—with others and with a higher Power—existential anxiety becomes, in Kierkegaard's word, a "school." The alcoholic is able to face and integrate his existential anxiety with his self–esteem. Tillich holds that it is only as existential anxiety is confronted and taken into self–affirmation of the person that it enriches rather than diminishes life. In his classic work, *The Concept of Dread*, Kierkegaard pointed out that in the very experience of facing anxiety an individual is educated to inner certitude or faith. This gives him the "courage to renounce anxiety without any anxiety, which only faith is capable of—not that it annihilates anxiety, but remaining ever young, it is continually developing itself out of the death throes of anxiety." [30]

The alcoholic in whom this has occurred has, as one of them put it, learned to "die living rather than live dying." Existential anxiety has become a life–enhancing force which has been responded to in such a way as to produce inner resources which aid rather than hinder the handling of neurotic anxiety.

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[30] S. Kierkegaard, *The Concept of Dread*, Transl Walter Lowrie (Princeton, NJ: Princeton University Press, 1944), p. 104.

SUMMARY

A tentative, theoretical structure is set forth as an approach to understanding the role of existential anxiety and its relationship to neurotic anxiety in the alcoholic. Certain evidence which suggests a dynamic interrelationship between alcohol and alcoholism, on the one hand, and religion, on the other, is reviewed. The thesis is presented and examined that one of the significant factors in the etiology of alcoholism is the vain attempt of the person to satisfy deep religious needs by means of alcohol. Psychoanalytic, sociological and philosophical views are presented and interrelated as they seem to contribute to an understanding of why the alcoholic tends to use alcohol in this way and thus mishandles his existential anxiety. The role of religious factors in recovery from alcoholism is discussed with particular emphasis on the conception of surrender.

FOR YOUR INFORMATION

In addition to the help offered through the Army Drug and Alcohol Prevention and Control Program, additional information is available from:

National Clearing House for Alcohol Information
Box 2345 Department S/S
Rockville, MD 20852

Alcoholics Anonymous
P.O. Box 459
Grand Central Station
New York, NY 10017

Alcohol and Drug Problems Association of North America
1101 15th Street, N.W., Suite 204
Washington, DC 20005

Council of State and Territorial Alcoholism Authorities
1101 15th Street, N.W., Suite 206
Washington, DC 20005

National Council on Alcoholism
2 Park Avenue South
New York, NY 10016

(Local AA Chapters, Al–Anon Family Groups, some Alateen groups, and local members of the National Council on Alcoholism are listed in most telephone directories.)

—Editor

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☆U.S. GOVERNMENT PRINTING OFFICE: 1976—621–783/1497

By Order of the Secretary of the Army:

BERNARD W. ROGERS
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Special